RETURNING PATIENT MEDICAL INFORMATION
TRIBECA PARK DERMATOLOGY

Patient Name:_____

Reason for Visit:_____

If your PCP has changed, Please provide name of new MD:_____

Medical History Changes

Any recent health changes/new medical conditions?:_____

Please provide an updated list of all medications:_____

_____

Any new allergies to medications?:_____

For women: Are you pregnant?_____Breast Feeding?_____

Family History

Any relatives recently diagnosed with skin cancer?: _____

Social History

Cigarette Smoking History (please check any that apply):

_____ **Never a smoker** ____ F**ormer smoker** ____ **Current daily smoker** ___**Current smoker some days**

Alcohol Consumption

How many times in the last year have you had 5 drinks or more in a single night? (circle one) **0 1-12 >12**

Current Review of Symptoms

Are you experiencing any of the following symptoms, currently? (check all that apply):

___ fever/chills	___ congestion/allergies	___ joint pain
___ significant change in weight	___ chest pain/pressure	___ muscle weakness
___ changes in vision	___ swelling of extremities	___ loss of sensation
___ changes in hearing	___ cough	___ headaches
___ earaches	___ shortness of breath	___ anxiety/depression
___ mouth sores	___ abdominal pain	___ easy bruising
___ nose bleeds	___ nausea/vomiting	___ lymph node swelling
___ sore throat	____ genitourinary symptoms	___ temperature intolerance

Signature of Patient:_____Date:_____