

NEW PATIENT MEDICAL INFORMATION
TRIBECA PARK DERMATOLOGY

***Are you currently experiencing a fever,
shortness of breath or any flu like symptoms?***

Yes _____ No _____

Patient Name: _____

Reason for Visit: _____

Medical History

Height _____ Weight _____

Medical Conditions (past and present): _____

Medications: _____

Allergies to Medication?: _____

For women: Are you pregnant? _____ Breast Feeding? _____

Skin History

Do you have a personal history of skin cancer, atypical moles, or precancerous skin growths?: _____

If "yes" what type and location: _____

Describe any past skin issues (such as eczema, psoriasis, acne, etc): _____

Family History

Family history of skin cancer?: ___ If "yes" please provide details _____

List any family history of skin conditions (such as eczema, psoriasis, acne, etc)?: _____

Social History

Cigarette Smoking History (please check any that apply):

___ Never a smoker ___ Former 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

Sun Exposure

Would you describe your past sun exposure as: Low _____ Moderate _____ High _____

Current Symptoms : (Check all that apply)

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

Signature of Patient: _____ Date: _____