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** ☐ **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**

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:_____