Patient Label

UT★Physicians

NEW PATIENT ADULT HEALTH HISTORY DERMATOLOGY

Date: _____

Last Name: _____ First Name: _____ M.I.:_____

Date of birth: _____ Gender ☐ Male ☐ Female

Preferred Pharmacy: _____ Pharmacy Phone #: _____

Pharmacy Fax #: _____

Referring Physician: Name: _____ Phone #: _____

Referring Physicians Fax #: _____

Primary Care Physician: Name: _____ Phone #: _____

Primary Care Physician Fax #: _____

Language preference: ☐ English ☐ Spanish ☐ Other:_____

Main reason/concern for your visit today: _____

Do you have vision or hearing impairment? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No ☐ Former Smoker ☐ Other form of tobacco: _____

If yes, how many cigarettes per day? _____ Are you interested in tobacco cessation help? ☐ Yes ☐ No

Do you drink alcohol ☐ Yes ☐ No drinks/week: _____

Do you wear sunscreen ☐ All the time ☐ Sometimes ☐ Rarely ☐ Never

Do you use a tanning bed ☐ Yes ☐ No

Occupation: _____

For Women: Are you pregnant ☐ Yes ☐ No ☐ Unsure/trying to become pregnant Are you breastfeeding ☐ Yes ☐ No

SURGICAL HISTORY Please list all prior operations below (with dates):

Type:	Date:

CURRENT MEDICATIONS

Do you have any food or drug allergies? ☐Yes ☐No If yes, please list:

_____

Environmental Allergies: ☐ Yes ☐ No Latex Allergy: ☐ Yes ☐ No If yes, please list:

_____

Please list current medications and vitamin/supplements you are taking: ☐None (Use back of form to list more)

Name:	Dose:	Times per day:	Refills 30 or 90 day supply:

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REVIEW OF SYMPTOMS

In the past 30 days check any symptoms you have experienced:

Constitutional Systems:
- ☐ Fever
- ☐ Weight Loss or gain
- ☐ Fatigue

Cardiovascular:
- ☐ Chest pain or palpitations
- ☐ Other: _____

_____

_____

_____

Genito-Urinary:
- ☐ Urinary frequency
- ☐ Urinary pain or blood

Males:
- ☐ Discharge, lesions or masses

Female:
- ☐ Vaginal bleeding or discharge
- ☐ Breast masses or discharge

Skin:
- ☐ Rashes or color changes
- ☐ Itching or dryness
- ☐ Hair or nail changes

Respiratory:
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing

Musculoskeletal:
- ☐ Joint pain, swelling, redness
- ☐ Muscle pain or cramps

Neurological:
- ☐ Headaches
- ☐ Numbness or tingling
- ☐ Weakness or paralysis
- ☐ Fainting or blackouts
- ☐ Slurred speech

Eyes:
- ☐ Loss of vision
- ☐ Distorted vision or haloes
- ☐ Fluctuating vision
- ☐ Eye pain or soreness

Endocrine:
- ☐ Excessive thirst of hunger
- ☐ Heat or cold intolerance

Hematology / Lymphatics / Immunology:
- ☐ Easy bruising / bleeding
- ☐ Blood transfusions
- ☐ Swollen lymph nodes

Psychiatric:
- ☐ Anxiety
- ☐ Depression
- ☐ Other: _____

_____

_____

_____

Ears, Nose, Mouth, Throat:
- ☐ Hearing difficulty
- ☐ Ringing or dizziness
- ☐ Sinus congestion
- ☐ Runny nose or post nasal drip
- ☐ Nosebleeds
- ☐ Dryness / Hoarseness

Gastrointestinal:
- ☐ Swallowing difficulty
- ☐ Vomiting / Heartburn

Other Symptoms not Listed:

_____

_____

_____

_____

PERSONAL MEDICAL PROBLEMS

Please check if you are having any of the following medical problems

Skin Cancer: -Basal cell carcinoma -Squamous cell carcinoma -Melanoma -Unknown type of skin cancer	☐ No	☐ Yes: Date, Location, Treatment:	
Atypical Moles ☐ Yes ☐ No	HIV ☐ Yes ☐ No	Hepatitis or liver problems ☐ Yes ☐ No	Eczema ☐ Yes ☐ No
History of organ transplant	☐ No	☐ Yes: Which organ, When:	
Heart Problems: -Coronary artery disease -Pacemaker -Artificial heart valve -Rheumatic fever	☐ No	☐ Yes: Specify which:	
Hay Fever ☐ Yes ☐ No	Asthma ☐ Yes ☐ No	Lupus ☐ Yes ☐ No	Sensitivity to sunlight ☐ Yes ☐ No
Joint problems/arthritis ☐ Yes ☐ No	Artificial joints	☐ No	☐ Yes: When:
High cholesterol ☐ Yes ☐ No	High blood pressure ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No	Kidney problems ☐ Yes ☐ No
Thyroid disease ☐ Yes ☐ No	Cancer (other than skin)	☐ No	☐ Yes: Type, date:
Bleeding problem ☐ Yes ☐ No	Weight loss or gain ☐ Yes ☐ No		

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FAMILY HISTORY Please indicate which, if any, immediate family members (parents, siblings, and children) have the current health conditions:

☐ Yes ☐ No	Melanoma:	
☐ Yes ☐ No	Other skin cancer:	
☐ Yes ☐ No	Autoimmune disease:	
☐ Yes ☐ No	Psoriasis:	
☐ Yes ☐ No	Eczema:	
☐ Yes ☐ No	Hay fever or asthma:	

I authorize you to leave a detailed voicemail with results or other health information on the specified phone: ☐No ☐ Yes, Phone #: _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor of any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Patient Signature **Date**

_____ _____

Physician Reviewed **Date**