



NEW PATIENT HISTORY

Name: _____ Date of Birth: _____

1. Primary reason for today's appointment? _____

How long have you had this problem? _____

Have you received treatment for this problem before today? _____

If yes, please describe. Include any non-prescription creams or medications you have tried: _____

2. Please list current medications: _____

3. Please list any allergies to medications: _____

4. Do you have or have you ever had any of the following:

Joints replaced: Yes No Liver Disease: Yes No

Kidney Disease: Yes No High Blood Pressure: Yes No

Diabetes: Yes No Heart Disease: Yes No

Nervous Disease: Yes No Blood Clot: Yes No

Asthma/Lung Disease: Yes No Keloid or Scar. Yes No

Genetic Disease: Yes No Do you bleed easily? Yes No

Have any blood relatives had melanoma or mole cancer? Yes No

Have you ever had skin cancer? Yes No

5. Is there anything else about your medical history which may be important for the doctor to know? _____