



Saints
MEDICAL GROUP
SAINTS DERMATOLOGY

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Board Certified in Dermatology

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Patient Name _____

Address _____

City, State, Zip _____

Date of Birth _____ Date of Visit: _____

SSN XXX-XX-_____ SEX: _____

New Patient Medical Information Sheet

Date: _____ Age _____

How were you referred to our clinic? _____

Physician (full name): Dr. _____

Did the requesting physician see you for your skin condition? No Yes

Friend (name): _____ Other (please specify): _____

Medical history: In your own words, please state the reason for your visit (**chief complaint**): _____

How long have you had this problem? (**duration**) _____

What parts of your body are affected? (**location**) _____

What makes it better? What makes it worse? (**change in severity**) _____

How does this problem bother you? (**symptoms**) _____

What treatments have you received for this problem? (**previous therapy**) _____

Is your problem worsening? stable? improving? (**timing**) Explain: _____

Review of Systems:

Skin: Have you seen a doctor for other skin problem? No Yes Which ones? _____

Do you have (please mark box(es) that apply): Hair loss skin cancer abnormal moles?

When you are exposed to sunlight, do you: _____

- 1) Always burn
- 2) Usually burn, rarely tan
- 3) Often burn, tan slowly
- 4) Sometimes burn, tan well
- 5) Rarely burn, always tan
- 6) Never burn, deeply tan

Women: Are you pregnant? No Yes Do you plan to become pregnant soon? No Yes

Are you nursing? No Yes

Past medical/family/social history: Please list all past major illnesses and operations: _____

Do you have an organ transplant? No Yes

Have you ever been diagnosed with HIV Hepatitis Lupus or other Connective Tissue Disease

Please list all medications you are currently taking: _____

Please list all drug and environmental allergies: _____

Is there a family history of a condition similar to yours? No Yes Additional information: _____

Is there a family history of (please make the box(es) that apply): adult acne asthma diabetes
 eczema hay fever genetic diseases hair loss melanoma psoriasis skin cancer

Additional information: _____

Occupation: _____

Do you smoke? No Yes Do you drink alcohol? No Yes

I have read and reviewed this form with the patient.

Patient Signature _____ Physician Signature _____