BRENTWOOD SKIN CLINIC - NEW PATIENT MEDICAL HISTORY

Name: _____ Date of Birth:_____Weight:_____Height: _____

What is the reason for your visit today?_____

_____

Dermatology/Skin History:

- ☐ Acne
- ☐ Abnormal Moles
- ☐ Allergies/Hay Fever
- ☐ Blistering Sun Burns
- ☐ Cold Sores/Fever Blisters
- ☐ Dry Skin
- ☐ Itchy or Flaking Scalp
- ☐ Eczema
- ☐ Pre-Cancerous Moles
- ☐ Psoriasis
- ☐ Poison Ivy/Oak
- ☐ Squamous Cell Carcinoma of skin
- ☐ Basal Cell Carcinoma of skin
- ☐ Malignant Melanoma
- ☐ Warts

Do you wear Sunscreen? Yes or No

If yes, what SPF? _____

Have you ever had a total body skin check? Yes or No

If yes, when? _____

Do you use a tanning salon? Yes or No

Medical Conditions:

Please describe any medical conditions that you currently have:

- ☐ NONE
- ☐ OTHER _____

_____

_____

_____

Medications: *Please list all medications you are currently taking: Or provide us with a copy*

Drug:_____Dosage:_____Frequency:_____ Reason:_____

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Drug:_____Dosage:_____Frequency:_____ Reason:_____

Drug:_____Dosage:_____Frequency: _____ Reason: _____

Allergies:

Please list all known allergies (environment, drug, food), as well as the type of reaction and level of severity:

- ☐ NONE
- ☐ OTHER _____

_____

_____

_____

Let us know if there is anything else you would like to disclose:

_____

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Name:_____ **Date of Birth**: _____

Smoking Status:

- ☐ NEVER
- ☐ Former Smoker
- ☐ Chewing Tobacco
- ☐ Some Day Smoker
- ☐ Every day Smoker
- ☐ E-Cigarette/Vape

If applicable:
Number of packs per day: _____
Total number of years of tobacco use: _____

Alcohol Consumption:

- ☐ None
- ☐ Less than 1 Drink per Day
- ☐ 1-2 Drinks per Day
- ☐ 3+ Drinks per Day
- ☐ Other: _____

Social History:

- ☐ Not Sexually Active
- ☐ Sexually Active with One Partner
- ☐ Sexually Active with Multiple Partners
- ☐ Patient Feels Safe at Home
- ☐ Patient Drives During the Day
- ☐ Patient Drives at Night
- ☐ Patient Exercises
- ☐ Patient Consumes Caffeine

Female Patients Only:

Last menstrual period:__/_____/_____ Are you pregnant? Yes or No Are you breast feeding? Yes or No

Have you received the Pneumonia Vaccine? Yes No If yes, when (what age/year)? _____

Have you received a Flu Shot this year? Yes No If yes, when (approximate date)_____

Have you received the Shingles Vaccine? Yes No I don't know If yes at what age/year? _____

Do you have an Advanced Care Plan? Yes No I don't know

Do you have a surrogate decision maker? Or Power of Attorney? Yes No I don't know

If yes, who is it? (Name, Tel # and relationship):

_____