Thunderbird
INTERNAL MEDICINE
A DIVISION OF ARIZONA
PRIMARY CARE PHYSICIANS, LLC

Dermatology New Patient History Form

Patient Name: _____ Date of Birth: ___/____/____ Today's Date: ___/____/____

Reason for today's visit: _____

Are you allergic to any medications (circle)? NO YES If yes, please list _____

Have you ever had dental anesthesia (Novocaine)? NO YES Any bad reaction? _____

List all medications you are currently taking (include prescriptions, over-the-counter meds, vitamins, herbals):

1. _____ 2. _____3. _____

4. _____ 5. _____6. _____

Do you have now, or have you ever had diseases or conditions of: (Please mark Yes or No for each)

	YES	NO		YES	NO
Bronchitis	____	____	Amputation	____	____
Emphysema	____	____	Thyroid	____	____
Asthma	____	____	Kidney	____	____
Chronic cough	____	____	Dialysis	____	____
Morning cough	____	____	Bladder	____	____
Shortness of breath	____	____	Frequency/burning urination	____	____
Wheezing	____	____	Stomach absorptive disorder	____	____
High blood pressure	____	____	GI issues with antibiotics	____	____
Chest pain	____	____	Yeast infection with antibiotics	____	____
Heart attack	____	____	Arthritis/joint deformity	____	____
Irregular heartbeat	____	____	Arthralgia	____	____
Phlebitis	____	____	Limited movement	____	____
Inflammation of vein	____	____	Artificial joint	____	____
Blood clot	____	____	Convulsions	____	____
Pacemaker	____	____	Epilepsy/seizure	____	____
Diabetes	____	____	Fainting	____	____
Excessive thirst/hunger	____	____	Other not listed: _____		

List surgical procedures you have had in the last 6 months: _____

Social History:

Do you drink alcohol? (circle)	NO	YES	If yes, _____ drinks per day
Do you use IV drugs? (circle)	NO	YES	If yes, what? _____ How often_____
Do you smoke? (circle)	NO	YES	If yes, how much _____
Have you been exposed to HIV/AIDS? (circle)	NO	YES	
(Women only) Are you pregnant? (circle)	NO	YES	If yes, due date _____

		YES	NO	
Skin:	Have you ever had skin cancer?	____	____	
	Has anyone in your family had skin cancer?	____	____	
	Do you have a history of any specific skin diseases?	____	____	If yes, explain _____
	Do you have problems with healing?	____	____	
	Do you develop keloids (scars) after surgery?	____	____	
	Do you bleed easily?	____	____	

Do you develop skin rashes in reaction to (mark all that apply):

___ Medications ____ Food ____ Environment ____ Bandages ____ Neosporin ____ Other

What is your occupation? _____ Hobbies? _____

What is your most current height? _____ft _____ inches Date of measurement _____

What is your most current weight? _____ pounds Date of measurement _____

Completed by (circle): Patient Caregiver Medical Assistant

_____

Patient Signature Date

Name of person completing this form if not the patient: _____