__ New Pt __ Update

Phoebe Rich Dermatology

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Name_____ Today's Date_____

Preferred pronouns _____ Age_____

▪**Purpose of today's visit: _____**

▪**Who were you referred by? _____**

▪**Who is your primary care doctor? _____Height _____Weight _____**

Please list medications or attach current medication list:

Current Medications	Approximate Start Date	Reason for taking medication

▪ **Do you have a PERSONAL HISTORY of pre-cancerous skin lesions (actinic keratoses) or skin cancer (basal cell carcinoma, squamous cell carcinoma or melanoma?** □ YES □ NO

If yes, please list skin cancer type(s) location, and approximate date of diagnosis:

_____

_____

_____

_____

▪ **Please list any OTHER HEALTH CONDITIONS you have. Include skin conditions, cancer, diabetes, heart disease, autoimmune disease, bleeding/clotting problems, depression/anxiety, etc.**

_____

_____

_____

_____

Are you or is there any chance that you might be pregnant? □ YES □ NO

Are you nursing? □ YES □ NO

▪ **Do you have any MEDICATION ALLERGIES (ex antibiotics, lidocaine, epinephrine, latex)?**

□ YES □ NO KNOWN MEDICATION ALLERGIES

If yes, please list the name of medication and type of reaction you experienced:

_____

_____

_____

▪ **Please list all significant SURGERIES AND HOSPITALIZATIONS and approximate dates:**

_____

_____

_____

▪ Do you have a FAMILY HISTORY of basal cell carcinoma, squamous cell carcinoma, or an unknown type of skin cancer? ☐ YES ☐ NO

▪ **Do you have a FAMILY HISTORY of melanoma?** □ YES □ NO

If yes, please list relationship of family member (s) who had melanoma:

_____

Sun History:

▪ How much sun exposure have you had? □ MINIMAL □ MODERATE □ EXTREME

▪ Have you ever had a blistering sunburn? □ YES □ NO

▪ Tanning bed use? □ YES □ NO □ History of tanning bed use

▪ Sunscreen Use: □ Daily □ Sometimes □ When going outdoors □ Other _____

▪ **Smoking habits:** □ Currently a smoker □ Former smoker □ Never smoked

▪ **Recreational drug use?** _____ ▪ **Medicinal marijuana use?** _____

▪ **What is your occupation?** _____ ▪ **Where did you grow up?** _____

Patient Signature_____ MD/PA Signature_____

By printing your name above, you indicate you have completed this form to the best of your knowledge.