Examination - New Patient

Patient Name: _____ DOB: _____ Date: _____

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CC:
HPI:
Location, Duration, Severity (mild, very, worsening), Signs & Symptoms (itchy, pain), Mod. Factors (prior tx), Quality (bleeding, inflamed), Timing, Context

Allergies to Medications: _____

Current Medications: _____

Current or Past Problems with: (Review of Systems)

Yes	No		Yes	No	
☐	☐	General Health	☐	☐	Lung
☐	☐	Arthritis/Muscles/Joints	☐	☐	Pacemaker
☐	☐	Blistering Sunburn	☐	☐	Psychological Disorder
☐	☐	Blood/Bleeding Disorder	☐	☐	Radiation Therapy
☐	☐	Ears/Nose/Throat/Mouth	☐	☐	Skin
☐	☐	Eyes	☐	☐	Stomach/Bowel
☐	☐	Headaches/Seizures	☐	☐	Thyroid/Diabetes
☐	☐	Heart	☐	☐	Altered Immune System(Immunosuppressant)/HIV
☐	☐	Kidneys			

If "Yes" to any, please explain: _____

Females: Are you pregnant? Yes__ No__ Planning to become pregnant? Yes__ No__

Family History:	Mother	Father	Siblings	Children
Allergies	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Eczema	☐	☐	☐	☐
Hayfever	☐	☐	☐	☐
Malignant Melanoma	☐	☐	☐	☐
Psoriasis	☐	☐	☐	☐
Skin Cancer-Non Melanoma	☐	☐	☐	☐

☐ **All Negative** (boxes checked)

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MD Counseled___

Social History: Do you live alone? Yes___ No___ Do you smoke? Yes___ No___
Do you drink alcohol? Yes ___ No___ Do you use recreational drugs? Yes ___ No___
Have you been vaccinated against: Influenza (flu shot)___ Pneumococcal pneumonia ___

Occupation: _____ Hobbies/Leisure Activities: _____

Signature of Patient or Parent if Under 18 yrs old _____ Date _____