

- Consult
- New
- Return

**CHICAGO LAKE SHORE  
MEDICAL ASSOCIATES**

Name: \_\_\_\_\_

Soc Sec #: \_\_\_\_\_

Age: \_\_\_\_\_

DOB: \_\_\_\_\_

**Dermatology New Patient History Form**

Date: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

Is your skin condition:  Itching  Painful  Bleeding  Growing  Changing

Duration of problem: \_\_\_\_\_

Past treatment: \_\_\_\_\_

Do you regularly use sunscreen?  Y  N SPF rating: \_\_\_\_\_

**Medical/Surgical History: please check any/all that apply:**

- Skin cancer \_\_\_\_\_
- Skin conditions \_\_\_\_\_
- Asthma \_\_\_\_\_
- Allergies \_\_\_\_\_
- Arthritis \_\_\_\_\_
- Cancer \_\_\_\_\_
- Diabetes \_\_\_\_\_
- Heart disease \_\_\_\_\_
- Pacemaker \_\_\_\_\_
- High blood pressure \_\_\_\_\_
- High cholesterol \_\_\_\_\_
- Hyperhidrosis (excessive sweating) \_\_\_\_\_
- Thyroid disease \_\_\_\_\_
- Other medical conditions: \_\_\_\_\_
- Prior surgeries: \_\_\_\_\_

**Social History:**

- Y N
- Tobacco \_\_\_\_\_
- Alcohol \_\_\_\_\_
- Tanning bed \_\_\_\_\_

Occupation: \_\_\_\_\_

Marital Status: \_\_\_\_\_

**Family History:**

- Y N
- Melanoma \_\_\_\_\_
- Other skin cancer \_\_\_\_\_
- Skin conditions \_\_\_\_\_

For females: are you pregnant or planning on trying to become pregnant in the near future? YES NO

Please list any prescription and/or over-the-counter medications you are currently taking, including herbals: \_\_\_\_\_

Allergies: \_\_\_\_\_

**Are you experiencing any of these symptoms?**

- |   |  |   |                                       |
|---|--|---|---------------------------------------|
| <input type="checkbox"/> Nausea                 | <input type="checkbox"/> Vomiting            | <input type="checkbox"/> Fevers             | <input type="checkbox"/> Chills       |
| <input type="checkbox"/> Chest pain             | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Cough              | <input type="checkbox"/> Headache     |
| <input type="checkbox"/> Difficulty with vision | <input type="checkbox"/> Abdominal pain      | <input type="checkbox"/> Diarrhea           | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Blood in the urine     | <input type="checkbox"/> Blood in the stool  | <input type="checkbox"/> Decreased appetite | <input type="checkbox"/> Depression   |
| <input type="checkbox"/> Weight loss            | <input type="checkbox"/> Weight gain         | <input type="checkbox"/> Joint pain         | <input type="checkbox"/> Muscle pain  |

**Do you have any of the following cosmetic skin care concerns? (Please circle)**

- |                     |                             |                                |
|---------------------|-----------------------------|--------------------------------|
| Fine lines/wrinkles | Redness/rosacea             | Frown lines/other facial lines |
| Crow's feet         | Dark circles under the eyes | Sun spots                      |
| Unwanted hair       | Scars                       | Other: _____                   |

**Are you interested in learning about any of the following? (Please circle)**

- |                                       |                    |                    |
|---------------------------------------|--------------------|--------------------|
| Botox®                                | Laser hair removal | Microdermabrasion  |
| Fillers (Juvederm®, Restylane®, etc.) | Chemical Peels     | Skin care products |
| Laser treatments                      |                    |                    |

History of present illness: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physical Exam: Vitals: Pulse \_\_\_\_\_ BP \_\_\_\_\_ Resp \_\_\_\_\_ Wt \_\_\_\_\_ Pain \_\_\_\_\_  
\_\_\_\_\_ male female \_\_\_\_\_ W/DWN \_\_\_\_\_ Thin \_\_\_\_\_ Obese

Alert/oriented x 3, Normal mood & affect Fitzpatrick phototype \_\_\_\_\_  
Type of skin exam performed: TBSE except genitals/waist up exam/focused exam

- \_\_\_\_\_ Erythematous scaly macules on the: \_\_\_\_\_
- \_\_\_\_\_ Tan/brown streak on papules on the: \_\_\_\_\_
- \_\_\_\_\_ Cherry red papules on the: \_\_\_\_\_
- \_\_\_\_\_ Tan & brown macules on the: \_\_\_\_\_
- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_
- 6. \_\_\_\_\_
- 7. \_\_\_\_\_
- 8. \_\_\_\_\_
- 9. \_\_\_\_\_
- 10. \_\_\_\_\_

- |                  |
|------------------|
| Sites examined:  |
| ____ Scalp       |
| ____ Face        |
| ____ Ears        |
| ____ Oral cavity |
| ____ Neck        |
| ____ Chest       |
| ____ Abdomen     |
| ____ Back        |
| ____ B/L UE      |
| ____ B/L LE      |
| ____ Buttocks    |
| ____ Digits      |
| ____ Nails       |

Assessment/Plan: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_ Nature of conditions reviewed. \_\_\_\_ Risks, benefits of all medications reviewed.  
\_\_\_\_ Biopsy today; see chart for procedure note. \_\_\_\_ Cryotherapy today; see chart for procedure note.  
\_\_\_\_ Skin tag removal today; see chart for procedure note.  
\_\_\_\_ Intralesional Kenalog injection today; see chart for procedure note.  
\_\_\_\_ Comedone extraction today; see chart for procedure note.

Education: \_\_\_\_ ABCDs of melanoma reviewed/daily use of UVA/UVB sunscreen advised.  
\_\_\_\_ Vitamin D supplementation recommended.  
\_\_\_\_ Handouts provided: Skin cancer Sun protection Other: \_\_\_\_\_  
\_\_\_\_ Samples given: \_\_\_\_\_  
Return to clinic in: \_\_\_\_\_

\_\_\_\_\_  
Torral Patel, MD Dictated \_\_\_\_\_ Typed \_\_\_\_\_ Paper \_\_\_\_\_  
Letter to: \_\_\_\_\_, MD