DERMATOLOGY NEW PATIENT HISTORY FORM – DR. CRIDER

BOONSLICK MEDICAL GROUP

Name:_____ Date of Birth: _____ Age: _____

Reason for Dermatology Visit:_____

Previous Dermatologist (if applicable):_____

Primary Care Physician:_____

Medication Allergies: _____

Pharmacy (Name/Address): _____

Current Medications/Doses:

_____

_____

_____

_____

_____

Medical Problems (Including History of Cancer):

_____

_____

_____

_____

_____

DERMATOLOGY HISTORY:

Personal History of Skin cancer: YES NO

Details of Skin Cancers If Known - Type (Basal Cell / Squamous Cell / Melanoma), Year, Location, Treatment

_____

_____

_____

_____

Family History of Melanoma: YES NO If yes, who / what age? _____

History of Tanning Bed Use: YES NO If yes, when / how long?_____

ADDITIONAL INFORMATION:

Pacemaker: Y N Defibrillator: Y N Blood Thinners: Y N

Current Smoker: Y N If yes, how much and for how long? _____

Height: _____ Weight:___ Occupation: _____