MASSACHUSETTS GENERAL HOSPITAL
DERMATOLOGY

Adult New Patient History Form

Print your name:
Print date of birth:
Medical Record Number: (*if known)*

PRIMARY CARE PHYSICIAN:

Physician Name: ______________________
Physician Address: ______________________
City: ______________ State: __________ Zip: __________
Telephone Number ( ) ______________

Did a physician refer you to the Dermatology Service? No Yes

❒ **Same as above**
Physician Name: ______________________
Physician Address: ______________________
City: ______________ State: __________ Zip: __________
Telephone Number ( ) ______________

I authorize Dermatology to leave messages on my (please check off):

Home Phone	( )
Day/Work Phone	( )
Cell Phone	( )

PRESENT PROBLEM(S):

What is the purpose of your visit today? ______________________

PAST HISTORY:

Do you have any medical problems? Please place a ✓ check mark and complete.

Diabetes ❒ Asthma ❒ Liver Disease ❒ Hay Fever ❒ High Blood Pressure ❒

Cancer ❒ (Specify type) ______________ Other ______________

Do you have a pacemaker?	❒ NO	❒ YES	
Do you have an artificial joint?	❒ NO	❒ YES	
Do you have an artificial heart valve?	❒ NO	❒ YES	
Do you have to take antibiotics before you go to the dentist?	❒ NO	❒ YES	Why?
Have you used tanning beds?	❒ NO	❒ YES	

MEDICATIONS: Do you take any prescription or over- the-counter medications regularly? Please list:

(1)	**(2)**	**(3)**
(4)	**(5)**	**(6)**

Are you allergic to any medications? NO YES If yes, please list: ______________

Do you take blood thinners? NO YES If yes, please list ______________

Have you taken any aspirin in the last 48 hours? NO YES

Please turn over and complete side 2

FAMILY HISTORY: Are there any diseases that run in your family? __ NO __ YES **(Please list)**

____

____

Do you or any of your blood relatives have melanoma?	❒ NO	❒ YES	(relationship)	
Do you or any of your blood relatives have non-melanoma skin cancer?	❒ NO	❒ YES	(relationship)	
Do you or any of your blood relatives have psoriasis?	❒ NO	❒ YES	(relationship)	
Do you or any of your blood relatives have eczema?	❒ NO	❒ YES	(relationship)	

SOCIAL HISTORY: Do you smoke? NO YES

Do you drink alcohol beverages on a regular basis? NO YES

OCCUPATION: What kind of work do you do? ______________________________

REVIEW OF SYSTEMS: Do you have any current or past problems with any of the following?

			Please describe:
General Health	❒ NO	❒ YES	
Eyes	❒ NO	❒ YES	
Ears/Nose/Throat/Mouth	❒ NO	❒ YES	
Heart	❒ NO	❒ YES	
Liver	❒ NO	❒ YES	
Lungs	❒ NO	❒ YES	
Stomach/Bowel	❒ NO	❒ YES	
Kidneys	❒ NO	❒ YES	
Headaches/Seizures	❒ NO	❒ YES	
Psychological Disorder	❒ NO	❒ YES	
Thyroid/Diabetes	❒ NO	❒ YES	
Blood/Bleeding Disorder	❒ NO	❒ YES	
Females: Are you pregnant?	❒ NO	❒ YES	
Planning to become pregnant?	❒ NO	❒ YES	

I authorize the Dermatology Service to release medical information to the referring physicians.

______________________________ ______________________________

Patient's Signature **Today's Date** **Physician's signature** **Today's Date**

REVISED 8/15/2011