Craig Singer MD Dermatology, PLLC
31000 Telegraph Road Suite 260 Bingham Farms, MI 48025
Phone: (248)792-3785 Fax: (248)792-2935

NEW PATIENT HISTORY FORM

- Name: _____
- Main Reasons for coming to the office:

_____

- Location of Problem(s): _____
- How severe is your problem (please circle): Mild / Moderate / Severe
- Duration of Problem (when did it first start?): _____
- **Itch**? YES/NO **Pain?** YES/NO **Growing/Changing**? YES/NO

Please circle any medical conditions that you currently have:-If none, circle **none** below

Anxiety	Hearing Loss
Arthritis	Hepatitis
Asthma/Seasonal Allergies	Hypertension
Atrial Fibrillation (Irregular Heartbeat)	HIV / AIDS
BPH (prostate enlargement)	High cholesterol
Bone Marrow Transplantation	Hyperthyroidism
Breast Cancer	Hypothyroidism
Colon Cancer	Leukemia
COPD	Lung Cancer
Coronary Artery Disease	Lymphoma
Depression	Prostate Cancer
Diabetes	Radiation Treatment
End Stage Renal Disease	Seizures
GERD (reflux)	Stroke

Other (please explain) _____ **NONE**

Please do not leave anything blank. If something does not apply please put N/A.

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● Name: _____

● Please list any prior surgeries and procedures (don't forget any heart, joint, skin procedures, C-section, tubal ligation, and hysterectomy).

_____

_____

For children under 2 years of age ONLY: Birth Weight _____ Gestation (e.g. 38weeks) ___

Skin disease History:
Have you had any of the following skin conditions (please circle)?

Acne	Flaking or Itchy Scalp
Actinic Keratosis (pre-cancer)	Melanoma
Basal Cell Skin Cancer	Poison Ivy
Blistering Sunburns	Precancerous (atypical/dysplastic) Moles
Dry Skin	Psoriasis
Eczema	Squamous cell skin cancer

Other (please explain)
_____

Do you wear normally wear Sunscreen? *YES / NO*

If yes, what SPF? _____

Have you been in a tanning salon more than 5 times during your entire life? *YES / NO*

Please do not leave anything blank. If something does not apply please put N/A.

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Family History:
Do you have a **Family History** of Skin Cancer**?** *YES / NO*

If Yes, please circle all that apply:

Basal Cell Skin Cancer

Squamous Cell Cancer

Melanoma

If yes, which relative? _____

Medications:
● Please list your medications and supplements (Include OTC products like aspirin, ibuprofen, Tylenol). Please include Birth control (*Condoms, Pill, IUD, Depo Provera)*

_____ _____ _____

_____ _____ _____

_____ _____ _____

● **Are you allergic to any medications? Yes / No**

If so, please list the date or year you had the reaction and what kind of symptoms you had, such as rash, itching, hives, shortness of breath, nausea, etc.

Social History: (please circle all that apply)

Currently smokes Recreational drug use

Has Smoked in the past **NONE**

Cautions/Alerts: (please circle all that apply)

Have you ever had difficulty stopping bleeding?	Yes	No
Do you require antibiotics prior to a surgical procedure?	Yes	No
Have you had an artificial joint replacement?	Yes	No
If yes, when and what body locations?		
_____		
Do you have an artificial heart valve?	Yes	No
Do you have a pacemaker?	Yes	No
Do you have a defibrillator?	Yes	No
Are you pregnant or currently trying to get pregnant?	Yes	No

Please do not leave anything blank. If something does not apply please put N/A.

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Review of Systems: Are you currently experiencing any of the following? (please check yes or no for the following)

Symptom	Yes	No
Abdominal Pain		
Anxiety		
Bloody Stool		
Bloody Urine		
Blurry Vision		
Changing Mole		
Chest Pain		
Cough		
Depression		
Fever or Chills		
Headaches		
Hay Fever		
Joint Aches		
Muscle Weakness		
Neck Stiffness		
Night Sweats		
Rash		
Seizures		
Shortness of Breath		
Sore Throat		
Thyroid Problems		
Unintentional Weight Loss		
Wheezing		
Keloids		

Were you referred by a physician? *YES/NO*

If yes, physician's' name _____

What is you preferred pharmacy? (Name and City)

_____

Please do not leave anything blank. If something does not apply please put N/A.