



# Longmont Clinic

## Dermatology New Patient Form

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Sex \_\_\_ M \_\_\_ F Age \_\_\_\_\_ Height \_\_\_\_\_ Approximate Weight: \_\_\_\_\_

Do you have any allergies to medications? \_\_\_yes \_\_\_no If yes please list below:

\_\_\_\_\_

List ALL medications you are currently taking (including prescriptions, over the counter, vitamins, and herbals):

\_\_\_\_\_

Skin: (please circle your answer)

Have you ever had skin cancer? Yes No

If yes, where and what type?

Have you ever had Malignant Melanoma? Yes No

Has anyone in your family had skin cancer? Yes No

Has anyone in your family had Melanoma? Yes No

If yes, who?

Do you have a history of any specific skin disease? YES NO

If yes, please list:

\_\_\_\_\_

Are you currently receiving any treatment for any specific skin diseases? YES NO

If yes, please list any treatment, including the name of the physician treating you and any medications you are currently using (prescription, over the counter, or herbal):

\_\_\_\_\_

List any surgical procedures that you have had in the last 6 months \_\_\_\_\_

\_\_\_\_\_

**Social History: (circle your answer)**

Do you drink alcohol? YES NO If yes, \_\_\_\_\_ drinks per day.

Do you use IV drugs? YES NO If yes, what? \_\_\_\_\_ How much? \_\_\_\_\_

Do you smoke? YES NO If yes, \_\_\_\_\_ packs per day.

Have you ever smoked? YES NO If yes, when did you quit? \_\_\_\_\_

Do you "dip" or "chew"? YES NO If yes, what? \_\_\_\_\_ How much? \_\_\_\_\_

Do you have AIDS or have you ever been exposed to HIV(AIDS)? YES NO

Have you been diagnosed with hepatitis or other liver problems? YES NO

Do you bleed easily? YES NO

Are you taking any blood thinners? (aspirin, ibuprofen, motrin, fish oil, Vitamin E, ginko)

YES NO

If yes, please list:

Do you have a pacemaker/defibrillator? YES NO

Do you have any artificial joints/heart valves/stents? YES NO

(Women)Are you pregnant or breastfeeding? YES NO

Do you take antibiotics prior to dental procedures? YES NO

How would you like to receive your biopsy results (if benign)? MAIL PHONE CALL

\_\_\_\_\_  
Patient or Guardian signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Reviewed by

\_\_\_\_\_  
Date

\*Please provide an E-Mail address if you wish to be notified for cosmetic specials!!! \_\_\_\_\_