NIGRO DERMATOLOGY GROUP

New Patient History-------In order to treat you safely and effectively, please answer the following questions. This is for our records only and responses are confidential.

Name:_____ Age:_____ Height_____ Weight____

What is the reason for your visit?_____
_____

How long has this been present?_____
_____

Allergies to medications:_____ No_____ Yes (please specify) _____
_____

Medications (please include non-prescription meds and birth control pills; write "no" if none):_____
_____

Do you take aspirin or blood thinners daily? _____Yes _____No

If you are female: Are you pregnant? ____Yes _____No Breastfeeding? ___Yes____No

Past Medical History/Family History

Lupus, Rheumatoid arthritis, other
Cancer
Diabetes
Eczema
Hayfever, Allergies, hives
Hepatitis---Type_____
Dysplastic nevi (abnormal moles)
Psoriasis
Skin Cancer(basal cell or squamous cell)
Thyroid Disease
AIDS/HIV

Transplantation
Heart Disease
Heart Murmurs or MVP
Artificial valve/pacemaker
High Blood Pressure
Bleeding disorder
Blood Transfusions
Joint Aches
Psychiatric Disorder
Bowel(crohn's/colitis)
Fever

List other medical problems:_____
_____
Prior Surgeries:_____
_____

Social History:
Marital status:_____ Occupation:_____
Do You Smoke? Packs per day:_____ Do you drink alcohol? Quantity:_____

Patient Signature_____Date:_____
Reviewed by: _____ Date:_____