Massachusetts General Hospital
Founding Member, Mass General Brigham

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

Patient Label Here

Do you have a **personal history** of the following?	Yes	No	
Melanoma skin cancer			
Basal cell skin cancer			
Squamous cell skin cancer			
Psoriasis			
Eczema			

Does anyone in **your family** have a history of the following?	Yes	No	If yes, which family member? (ex. mother/father/sibling/child)
Melanoma skin cancer			
Basal cell skin cancer			
Squamous cell skin cancer			
Eczema			
Psoriasis			

SOCIAL HISTORY:

Occupation: What kind of work do you do? _____

Alcohol: Do you drink alcohol on a regular basis? ❑ Yes ❑ No

Tobacco: Please provide us with your current smoking status:

❑ Never smoker ❑ Current every day smoker ❑ Current some day smoker ❑ Former smoker

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

			Please describe:
GENERAL HEALTH	❑ NO	❑ YES	
EYES	❑ NO	❑ YES	
EARS/NOSE/MOUTH/THROAT	❑ NO	❑ YES	
HEART	❑ NO	❑ YES	
LIVER	❑ NO	❑ YES	
LUNGS	❑ NO	❑ YES	
STOMACH/BOWELS	❑ NO	❑ YES	
KIDNEYS	❑ NO	❑ YES	
HEADACHES/SEIZURES	❑ NO	❑ YES	
PSYCHOLOGICAL DISORDERS	❑ NO	❑ YES	
THYROID/DIABETES	❑ NO	❑ YES	
BLOOD/BLEEDING DISORDER	❑ NO	❑ YES	
FEMALES: ARE YOU PREGNANT?	❑ NO	❑ YES	
PLAN TO BECOME PREGNANT?	❑ NO	❑ YES	

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

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