

NIGRO DERMATOLOGY GROUP, P.A.
Dermatology – Dermatologic Surgery
Cosmetic Dermatology

New Patient Health 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)
 Malignant Melanoma
 Psoriasis
 Skin Cancer (basal cell or squamous cell)
 Thyroid disease
 AIDS/HIV

Yourself

Blood relative

Review of Systems

Transplantation
 Heart disease
 Heart murmurs or MVP
 Artificial valve/pacemaker
 High blood pressure
 Bleeding disorder
 Blood transfusions
 Joint aches
 Artificial joint
 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:** _____