





**Dermatology Center** of Canyon County  
**NEW PATIENT**

**PLEASE COMPLETE THE FOLLOWING INFORMATION:**

Date: \_\_\_\_\_  
 Name: \_\_\_\_\_ Age: \_\_\_\_\_  
 Referring MD: \_\_\_\_\_  
 Primary MD: \_\_\_\_\_

**Check the appropriate box if you or your family members have had any of the following conditions:**

CONDITION	you	mom	dad	other	CONDITION	you	mom	dad	other	CONDITION	you	mom	dad	other
Stroke					Asthma					Thyroid disease				
Diabetes					Emphysema					Arthritis				
Artificial valve					Hepatitis					Seasonal allergies				
Artificial joint					Seizures					Eczema				
Heart Disease					Organ transplant					Psoriasis				
High blood pressure					Immune suppression					Cancer Type:				
Chest pain					HIV or AIDS					Melanoma				
Pneumonia					Kidney disease					Skin cancer				
Other Health conditions. List: _____														

Do you have any allergies to medications?  No  Yes \_\_\_\_\_  
 Are you currently pregnant?  No  Yes  N/A Are you planning a pregnancy?  No  Yes  N/A  
 Do you require antibiotics before dental work or other procedures?  No  Yes  
 Spouse's name (if applicable): \_\_\_\_\_ Number of children (if applicable): \_\_\_\_\_  
 Do you smoke?  No  Yes Amount \_\_\_\_\_ Do you drink alcohol?  No  Yes Amount \_\_\_\_\_

**Do you have any of the following symptoms?**

Weight loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Abdominal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Muscle/joint pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Lymph nodes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Change in vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain/Difficulty urinating	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nausea/vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other	_____

Do you have a history of blistering sunburn?  Yes  No Do you wear sunscreen daily?  Yes  No

**List all medications you are currently taking (include over-the-counter medications, vitamins and herbals).**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Reason for today's visit:** \_\_\_\_\_

**OFFICE USE ONLY**

\_\_\_\_\_  
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