Staff use only:
Appt Time:_______________________
Check-in Time:_____________________
New or F/u to MassDerm: ☐New ☐F/u

Appt Reason:_____________________
Provider:_________________
Room:

Patient Label

NEW PATIENT QUESTIONNAIRE

Name:	Date of Birth:
Primary Care Physician:	Name of Referring Physician (if not primary care physician):
Preferred Pharmacy Name, City, and Street Address:	

General Medical History: (Please circle all that apply or NONE)

NONE	Diabetes	Thyroid Problem (underactive)
Anxiety	End Stage Renal Disease	Lymphoma
Arthritis	High Blood pressure	Radiation Treatment (Reason:___________)
Asthma		

OTHER:_____________________________

Skin Disease History (Please circle all that apply or NONE)

NONE	Eczema	Precancerous or Atypical Moles
Acne	Hay Fever/Allergies	Psoriasis
Basal Cell Skin Cancer	**Melanoma (location / year:___________)**	Squamous Cell Skin Cancer

OTHER:_____________________________

Do you have a family history of melanoma? ☐ No ☐ Yes If yes, which relative?______________________

Medications (List medications or circle NONE)

NONE
Please list all of your current medications:

Allergies (List allergies or circle NONE)

NONE
Please list all of your medication allergies:

Social History

What is/was your occupation?________________________ Are you retired? ☐ No ☐ Yes
What name would you like to be called?________________________

PLEASE TURN OVER AND COMPLETE OTHER SIDE

Review of Systems / Alerts		
Do you have any fevers or chills today?	□ No	□ Yes ______________________________
Have you had bad reaction to lidocaine?	□ No	□ Yes ______________________________
Have you had bad reaction to epinephrine?	□ No	□ Yes ______________________________
Do you have an allergy to latex?	□ No	□ Yes ______________________________
Do you have a pacemaker?	□ No	□ Yes ______________________________
Do you have a defibrillator	□ No	□ Yes ______________________________
Do you have an artificial heart valve	□ No	□ Yes ______________________________
Do you take blood thinners?	□ No	□ Yes ______________________________
Do you have problems with bleeding?	□ No	□ Yes ______________________________
Have you ever been infected with hepatitis B or C?	□ No	□ Yes ______________________________
Do you have HIV?	□ No	□ Yes ______________________________
Have you had artificial joints within past 2 years?	□ No	□ Yes ______________________________
Do you require premedication prior to procedures?	□ No	□ Yes ______________________________
Are you pregnant, planning a pregnancy, or breastfeeding?	□ No	□ Yes ______________________________

MassDerm offers the option of a free cosmetic consultation with our nurse to answer questions you may have about improving or maintaining your skin's appearance and treating wrinkles, brown sun spots, redness, skin texture or acne scars.		
Would you be interested in meeting with our nurse either after today's visit (if she has availability) or at a future visit?	□ No	□ Yes

With my signature below, I submit that the above information is accurate to the best of my knowledge.

____ ____________________

Patient (or Guardian) Signature Date

Staff Use Only Below This Line:

1
- Staff initials:________
- Pharmacy
- Portal
- Complete "Staff Use Only" box at top of this form (except for room)
- Clipboard

2
- Staff initials:________
- Visit settings (confirm new/established; provider)
- ROS (including Alerts)
- Pref name (sticky)

3
- iPad photo
- Know provider? (sticky)
- CC x 2 max (+/- FSE)

4
- Protocol (for FSE) / Exam (for non-FSE)