

NEW PATIENT HISTORY & PHYSICAL

Welcome to the office of Greater Washington Dermatology, PA (Montgomery County)/Capital Dermatology, PA (Annapolis). This form is a permanent part of your medical record. Please complete this questionnaire as carefully and completely as possible. Complete all sections except the box marked "HPI". Please print. Thank you.

NAME _____, Age _____, Sex: M F, Today's Date _____

What is/are the reason(s) for your visit? (please **limit** yourself to **three items**):

- 1.
- 2.
- 3.

HPI (Patients—leave this section blank—continue with "Allergies"):

<i>Gen'l</i>			
<i>Loc'n</i>			
<i>Dur'n</i>			
<i>Sev'y</i>			
<i>Timing</i>			
<i>Mod fact'r</i>			
<i>Ass'd sig/sx</i>			
<i>Qual/contxt</i>			

ALLERGIES (rash, hives, shortness of breath):
1.
2.
3.

INTOLERANCE (upset stomach, headache, diarrhea):
1.
2.
3.

<i>Please CIRCLE any cosmetic concerns:</i>	
Reducing wrinkles	Microdermabrasion
Botox	Leg/facial vein laser
Collagen	Chemical peels
Laser	Glycolic acid
Hair removal laser	

MEDICATIONS		
Name	Strength	How often
1.		
2.		
3.		
4.		
5.		
6.		

HERBS/DIETARY SUPPLIMENTS
List below:
1.
2.
3.
4.
5.
6.

Name: _____

PAST MEDICAL HISTORY—Please circle ALL dermatologic or medical conditions that you have had or currently have:

- | | | | |
|-----------------------------------|-------------------------|-----------------------------------|---------------------------------|
| Skin cancer | Ear-nose-throat disease | Lung disease/TB | Gout |
| Acne | Seizures/fainting | Thyroid disease | Lupus/sarcoidosis |
| Warts | Stroke/TIA | Diabetes | Scleroderma |
| Scars/keloids | Mouth/gum disease | Stomach ulcers/digestive problems | Any type of cancer |
| Fungus | Heart disease | Gall bladder disease | Exposure to toxins or radiation |
| Hives | Heart murmur | Liver disease | Other problems—
list: _____ |
| Shingles | Pacemaker/defibrillator | Blood disorder | _____ |
| Psoriasis/eczema | High blood pressure | Kidney disease | _____ |
| Eye
disease/glaucoma/cataracts | High cholesterol | Arthritis | |
| | Asthma | | |

LIST ANY SURGERIES:

FAMILY HISTORY:

	Medical problems/cause of death if applicable
Mother	
Father	
Sibling	
Sibling	

- **What is your occupation?** : _____
- **Do you smoke?** _____ **Do you drink alcohol?** _____ **Do you use sunscreen?** _____

FOR WOMEN: Are you currently pregnant, trying to become pregnant, or are you nursing? _____

REVIEW OF SYSTEMS: Please circle any that apply---

- | | |
|---------------------------------|---------------------------------------|
| Fevers | Chest pain |
| Night sweats | Nausea/vomiting/constipation/diarrhea |
| Acute visual or hearing changes | Urinary frequency/urgency/burning |
| Trouble swallowing | Joint/muscle pains |
| Chronic cough | Depression |
| Shortness of breath | Seizures/fainting |

NAME: _____

PHYSICAL EXAMINATION:

- Constitutional: General appearance: Grooming: _____ Development: _____ Nourishment: _____
- Neurological: Alert? _____, oriented? _____, (check for yes, write "no" for no)
- Mood/affect _____

Skin/subcutaneous/mms:	nl	abn	Comments
• Conjunctivae/Lids			
• Lips/teeth/gums			
• Oropharynx			
• Periph edema/varicosities			
• Lymph nodes			
• Extremities (c,c,e)			
• Head & face			
• Neck			
• Chest incl brst/axil			
• Abdomen			
• Genitalia/groin/buttocks			
• Back			
• Right upper extremity			
• Left upper extremity			
• Right lower extremity			
• Left lower extremity			
• hyper, chrom- brom- hidrosis			

99203 >=12

IMPRESSION/PLAN: