J.M. Brock, Jr., MD • Heather Newlon, MD • Brooke Edwards, DCNP
McComb Skin Clinic, P.A.

Date: _____ **Chart:** _____

Name: _____ **Date of Birth:** _____

Why have you come to see the doctor today? _____

_____

May we leave a detailed message on your preferred phone number? YES ☐ NO ☐

Who is your Primary Care Doctor? _____

Past Medical History

Have you ever had:	YES	NO		YES	NO
Alzheimer's	☐	☐	Hearing Loss	☐	☐
Anxiety	☐	☐	Heart Attack	☐	☐
Arthritis, Specify (_____)	☐	☐	Hepatitis, Specify (_____)	☐	☐
Asthma	☐	☐	High Blood Pressure	☐	☐
Atrial fibrillation (Irregular Heartbeat)	☐	☐	High Cholesterol	☐	☐
Autoimmune disorders	☐	☐	HIV/AIDS	☐	☐
Cancer, Specify (_____)	☐	☐	Hyperthyroidism	☐	☐
COPD	☐	☐	Hypothyroidism	☐	☐
Coronary Artery Disease	☐	☐	Jaundice	☐	☐
Crohn's/Ulcerative Colitis	☐	☐	Keloids	☐	☐
Depression	☐	☐	Kidney Disease	☐	☐
Diabetes (**Last A1C**_____)	☐	☐	Seizure/Epilepsy	☐	☐
End Stage Renal Disease	☐	☐	Stroke	☐	☐
Gout	☐	☐	Tuberculosis	☐	☐
GERD (Acid Reflux)	☐	☐	Organ Transplant (_____)	☐	☐
Peptic Ulcer	☐	☐			

Past Surgical History

Please list all surgeries

1._____ **5.**_____ **9.**_____ **13.**_____

2._____ **6.**_____ **10.**_____ **14.**_____

3._____ **7.**_____ **11.**_____ **15.**_____

4._____ **8.**_____ **12.**_____ **16.**_____

SEE BACK OF PAGE >

Date: _____ **Chart:** _____

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Skin Disease History

Have you ever had:	YES	NO		YES	NO
Acne / Rosacea	☐	☐	Squamous Cell Skin Cancer	☐	☐
Actinic Keratoses	☐	☐	Herpes Simplex (Cold Sores)	☐	☐
Basal Cell Skin Cancer	☐	☐	Herpes Zoster (Shingles)	☐	☐
Eczema	☐	☐	Do you wear Sunscreen?	☐	☐
Flaking or Itchy Scalp	☐	☐	Do you use a tanning bed?	☐	☐
Hay Fever	☐	☐	Do you have a family history →	→	
Melanoma	☐	☐	→ of Melanoma?	☐	☐
Precancerous Moles	☐	☐	If Yes, what relative? _____		
Psoriasis	☐	☐			

Medications

Please list all medications, vitamins & herbs you are currently taking, **INCLUDING ASPIRIN**.

Name Strength/Dosage Taken/How Often

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Allergies

Do you have any drug allergies? Yes No If yes, please list:_____

Please list any food, seasonal and contact allergies: _____

Social History

Tobacco Products: ( ) Never ( ) Current - Every Day ( ) Current-Some Days ( ) Former

(This Question is a requirement of the Federal Government.)

Professional Occupation:_____ Workplace:_____

Do you live alone? (Please Circle) YES NO

Date: _____ **Chart:** _____

Name: _____ **Date of Birth:** _____

Family Medical History – 1ST DEGREE RELATIVES ONLY (PARENTS / SIBLINGS / CHILDREN)

Do you have a family history of	YES	NO		YES	NO
Asthma	☐	☐	Hay fever	☐	☐
Atopic Dermatitis/Eczema	☐	☐	Melanoma	☐	☐
Blistering Disorder	☐	☐	Non-Melanoma Skin Cancer	☐	☐
Cancer, Specify (_____)	☐	☐	Psoriasis	☐	☐

Review of Systems: Are you currently experiencing any of the following? Check YES to those that apply.

Do you currently have:	YES	NO		YES	NO
Problems with bleeding	☐	☐	Fever or Chills	☐	☐
Problems with healing	☐	☐	Night Sweats	☐	☐
Problems with scarring	☐	☐	Unintentional weight loss	☐	☐
Rash	☐	☐	Joint Aches	☐	☐
Immunosuppression	☐	☐	Muscle Weakness	☐	☐
Hay Fever	☐	☐			

!!! MEDICAL ALERTS !!!

Please check yes to any that apply.	YES	NO		YES	NO
Allergy to Adhesive	☐	☐	MRSA	☐	☐
Allergy to Lidocaine	☐	☐	Pacemaker/Defibrillator	☐	☐
Allergy to topical antibiotic ointments	☐	☐	Antibiotics prior to surgery/dental procedures	☐	☐
Artificial Heart Valve	☐	☐	Pregnant or planning pregnancy	☐	☐
Artificial joints (within last 2 years)	☐	☐	Currently Breastfeeding	☐	☐
Blood Thinners (aspirin, Plavix, Coumadin, Pradaxa, Xarelto, Eliquis, Brilinta, Ticlid, generic)				☐	☐

********** **********

Did you receive the pneumonia vaccine in the last 5 years? ☐ ☐

Did you receive the flu vaccine in the last year? ☐ ☐

If NO *– Are you allergic to the flu vaccine?* ☐ ☐