

**J.M. Brock, Jr., MD • Heather Newlon, MD • Charly Schmidt, FNP-C
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? _____ Preferred Pharmacy: _____

Past Medical History

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

Other: _____

Past Surgical History

Please list all surgeries

- | | | | |
|----------|----------|-----------|-----------|
| 1. _____ | 5. _____ | 9. _____ | 13. _____ |
| 2. _____ | 6. _____ | 10. _____ | 14. _____ |
| 3. _____ | 7. _____ | 11. _____ | 15. _____ |
| 4. _____ | 8. _____ | 12. _____ | 16. _____ |

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

<i>Do you have a family history of</i>	YES	NO		YES	NO
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever	<input type="checkbox"/>	<input type="checkbox"/>
Atopic Dermatitis/Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Melanoma	<input type="checkbox"/>	<input type="checkbox"/>
Blistering Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Non-Melanoma Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Cancer, Specify (_____)	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>

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

<i>Do you currently have:</i>	YES	NO		YES	NO
Problems with bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Fever or Chills	<input type="checkbox"/>	<input type="checkbox"/>
Problems with healing	<input type="checkbox"/>	<input type="checkbox"/>	Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>
Problems with scarring	<input type="checkbox"/>	<input type="checkbox"/>	Unintentional weight loss	<input type="checkbox"/>	<input type="checkbox"/>
Rash	<input type="checkbox"/>	<input type="checkbox"/>	Joint Aches	<input type="checkbox"/>	<input type="checkbox"/>
Immunosuppression	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>			

!!! MEDICAL ALERTS !!!

	YES	NO		YES	NO
Allergy to Adhesive	<input type="checkbox"/>	<input type="checkbox"/>	MRSA	<input type="checkbox"/>	<input type="checkbox"/>
Allergy to Lidocaine	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker/Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>
Allergy to topical antibiotic ointments	<input type="checkbox"/>	<input type="checkbox"/>	Antibiotics prior to surgery/dental procedures	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant or planning pregnancy (Circle one)	<input type="checkbox"/>	<input type="checkbox"/>
Artificial joints (within last 2 years)	<input type="checkbox"/>	<input type="checkbox"/>	Currently Breastfeeding	<input type="checkbox"/>	<input type="checkbox"/>
Blood Thinners (aspirin, Plavix, Coumadin, Pradaxa, Xarelto, Eliquis, Brilinta, Ticlid, generic)				<input type="checkbox"/>	<input type="checkbox"/>

1) **Do you have an Advance Directive?** (Healthcare Power of Attorney)

YES ____ NO ____

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Skin Care Concerns

- Main Concern: _____
- Skin Type: dry/oily/normal/combo _____
- Lifestyle / Hobbies: _____
- Willing to treat aggressively? mild/moderate / aggressive _____
- Previous Treatments / Satisfied? _____

- Current Skin Care Regimen and Products: _____

- Any other concerns: _____

Please disregard this page if not applicable.