ROBERT B. HOPP, M.D.
& ASSOCIATES

CENTER FOR EXCELLENCE IN
DERMATOLOGY™
PLLC

FOR OFFICE USE ONLY

❑ New ❑ Follow-up
❑ Patient seen in last 4 weeks
PROVIDER: _____
APPT. TIME: _____
CHECK IN: _____
ROOMED: _____
CHECK OUT: _____

❑ Asuris Northwest Health
❑ Anthem Blue Cross Blue Shield
❑ Premera Blue Cross
❑ First Choice Health
❑ LifeWise of Washington
❑ LifeWise Health Plan of Oregon
❑ Regence
❑ Uniform Medical Plan
❑ Medicare
❑ Other: _____

Medical History

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Dr. Hopp works with six nurse practitioners and one physician assistant. All of our providers are trained in dermatology and consult with one another whenever problems arise that are outside their knowledge base.

Full body exams are very important in the diagnosis of skin cancers. A gown must be worn for this examination. Would you like a full body skin exam today? ❑ Yes ❑ No

Please tell us about the skin problems that bring you to the office today:

Chief Complaint #1

Description:

History:

Location on body:

Severity of problem:

Past treatment(s):

Effect of treatment(s):

Chief Complaint #2

Description:

History:

Location on body:

Severity of problem:

Past treatment(s):

Effect of treatment(s):

PROVIDER

INITIALS: _____
DATE: _____

INITIALS: _____
DATE: _____

INITIALS: _____
DATE: _____

INITIALS: _____
DATE: _____

Patient Name: _____ Date of Birth: _____

Medical History

Please indicate if you are currently having or have had trouble with any of the following conditions:

Melanoma	❑ No	❑ Yes	If yes, location on body: _____
Basal Cell	❑ No	❑ Yes	If yes, location on body: _____
Squamous Cell	❑ No	❑ Yes	If yes, location on body: _____
Cancer (not skin)	❑ No	❑ Yes	If yes, location on body: _____
Acne	❑ No	❑ Yes	If yes: _____
Eczema	❑ No	❑ Yes	If yes: _____
Psoriasis	❑ No	❑ Yes	If yes: _____
Asthma	❑ No	❑ Yes	If yes: _____
Allergies / Hay fever	❑ No	❑ Yes	If yes: _____
Heart Problems	❑ No	❑ Yes	If yes: _____
Kidney Problems	❑ No	❑ Yes	If yes: _____
Diabetes	❑ No	❑ Yes	If yes: _____
High Cholesterol	❑ No	❑ Yes	If yes: _____
Excessive Bleeding	❑ No	❑ Yes	If yes: _____
High Blood Pressure	❑ No	❑ Yes	If yes: _____
Peptic Ulcer Disease	❑ No	❑ Yes	If yes: _____
Hepatitis	❑ No	❑ Yes	If yes: _____
Autoimmune Disorder	❑ No	❑ Yes	If yes: _____
Allergy to sun	❑ No	❑ Yes	If yes: _____

Amount of sun exposure you've had in your life: ❑ Mild ❑ Moderate ❑ Severe

If female, are you pregnant or breastfeeding? ❑ No ❑ Yes: _____

Do you have artificial joints or heart valves? ❑ No ❑ Yes: _____

Do you have a pacemaker? ❑ No ❑ Yes: _____

What surgeries have you had in the past?

Any other medical problems not listed above?

List the names of current doctors:

_____

_____

_____

_____

PROVIDER

INITIALS: _____
DATE: _____

INITIALS: _____
DATE: _____

INITIALS: _____
DATE: _____

INITIALS: _____
DATE: _____

Patient Name: _____ Date of Birth: _____

Please list any prescription and over-the-counter medications you are currently taking:

Please list any prescription and over-the-counter medications you are ALLERGIC to, and the reaction you have had to them:

Please list the pharmacy that you use the most, including mail orders:

Review of Systems

Fever / chills? ❑ No ❑ Yes: _____

Feeling well otherwise? ❑ Yes ❑ No: _____

Circle any of the following skin symptoms you are experiencing:

Bruising	Color Change	Scar/keloids	Swelling	Itching
Lesions/sores/growths	Lumps	Rash	Hair problems	Nail problems

Family History

Has anyone in your family had the following problems?

Melanoma	❑ No	❑ Yes	If yes, who? _____
Basal Cell	❑ No	❑ Yes	If yes, who? _____
Squamous Cell	❑ No	❑ Yes	If yes, who? _____
Acne	❑ No	❑ Yes	If yes, who? _____
Eczema	❑ No	❑ Yes	If yes, who? _____
Psoriasis	❑ No	❑ Yes	If yes, who? _____
Other	❑ No	❑ Yes	If yes, who? _____

Has anyone in your family had skin problems similar to what you're here for today?

❑ No ❑ Yes If yes, who? _____

Social & Behavioral History

Do you use tobacco of any kind? ❑ No ❑ Yes If yes, what type: _____

Do you wear sunscreen regularly? ❑ No ❑ Yes If yes, SPF: _____

Do you use alcohol on a regular basis? ❑ No ❑ Yes If yes, amount: _____

Occupation: _____

Marital status: _____

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REVIEWED: ❑ PROVIDER SIGNATURE _____ DATE: _____

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