



FOR OFFICE USE ONLY		<input type="checkbox"/> UnitedHealthcare
<input type="checkbox"/> New	<input type="checkbox"/> Follow-up	<input type="checkbox"/> Asuris Northwest Health
<input type="checkbox"/> Patient seen in last 4 weeks		<input type="checkbox"/> Anthem Blue Cross Blue Shield
PROVIDER: _____		<input type="checkbox"/> Premera Blue Cross
APPT. TIME: _____		<input type="checkbox"/> First Choice Health
CHECK IN: _____		<input type="checkbox"/> LifeWise
ROOMED: _____		<input type="checkbox"/> AARP
CHECK OUT: _____		<input type="checkbox"/> Regence
		<input type="checkbox"/> Medicare
		<input type="checkbox"/> Other: _____

Medical History PATIENT TO COMPLETE

Appointment Date: _____

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

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

Do you need a gown for your exam today? Yes No

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

Problem #1

Describe the problem:

How long have you had the problem:

Where on your body are you having the problem:

How severe is the problem:

Previous treatment(s) you've tried for the problem:

Did treatment(s) help:

Problem #2

Describe the problem:

How long have you had the problem:

Where on your body are you having the problem:

How severe is the problem:

Previous treatment(s) you've tried for the problem:

Did treatment(s) help:

Patient Name: _____ Date of Birth: _____

Skin Review of Systems

Are you having any of these skin symptoms?

- | | | | |
|---------------------|--|---------------------------------|--|
| Excessive bleeding: | <input type="checkbox"/> No <input type="checkbox"/> Yes | Keloid scar formation: | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Poor wound healing: | <input type="checkbox"/> No <input type="checkbox"/> Yes | Nail problems: | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Sensitivity to sun: | <input type="checkbox"/> No <input type="checkbox"/> Yes | Sensitive skin: | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Easy bruising: | <input type="checkbox"/> No <input type="checkbox"/> Yes | Allergy to topical antibiotics: | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Hair problems: | <input type="checkbox"/> No <input type="checkbox"/> Yes | Allergy to Band-Aids: | <input type="checkbox"/> No <input type="checkbox"/> Yes |

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

Medical History

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

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

What surgeries have you had in the past?

Any other medical problems not listed above?

Patient Name: _____ Date of Birth: _____

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: _____

List the names of current doctors:

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 — Are you experiencing any of the following?

Fever / chills? No Yes: _____

Feeling fatigued? No Yes: _____

Joint aches associated with skin symptoms? No Yes: _____

Trouble sleeping because of skin problem? No Yes: _____

History of weight loss associated with skin problem? No Yes: _____

Activity level restricted because of skin problem? No Yes: _____

Are you very worried and anxious about skin problems? No Yes: _____

Patient Name: _____ Date of Birth: _____

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: _____

REVIEWED: PROVIDER SIGNATURE _____ DATE: _____