ROBERT B. HOPP, M.D.
& ASSOCIATES

CENTER FOR EXCELLENCE IN DERMATOLOGY™ PLLC

Dr. Hopp works with nurse practitioners and physician assistants. All of our providers are trained in dermatology and consult with one another whenever problems arise that are outside their knowledge base. Sometimes when there are numerous, complicated or difficult problems it is not possible to address all of the patient's concerns in one office visit, but we will do our best with the time available.

Medical History
PATIENT TO COMPLETE

Appointment Date: _____

Patient Name: _____ Date of Birth: _____ Weight: _____

Patient Signature: _____ Date: _____

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

Problem #1

How long has the problem been present? _____

Where on your body are you having the problem? _____

Is the problem getting better or worse? _____

How severe is the problem? _____

What medications have been used to treat the problem? _____

What did the treatments do to the problem? _____

Problem #2

How long has the problem been present? _____

Where on your body are you having the problem? _____

Is the problem getting better or worse? _____

How severe is the problem? _____

What medications have been used to treat the problem? _____

What did the treatments do to the problem? _____

Skin Review of Systems— Are you having any of these skin symptoms?

Excessive bleeding:	❑ No ❑ Yes	Keloid scar formation:	❑ No ❑ Yes
Poor Wound Healing:	❑ No ❑ Yes	Nail Problems:	❑ No ❑ Yes
Sensitivity to sun:	❑ No ❑ Yes	Sensitive skin:	❑ No ❑ Yes
Easy bruising:	❑ No ❑ Yes	Allergy to topical antibiotics:	❑ No ❑ Yes
Hair problems:	❑ No ❑ Yes	Allergy to Band-Aids	❑ No ❑ Yes

PROVIDER INITIALS _____ DATE: _____

Review of Systems — Are you experiencing any of the following?

Feeling fatigued? ❑ No ❑ Yes:	Do you have a pacemaker? ❑ No ❑ Yes:
Joint aches and pains? ❑ No ❑ Yes:	Are you very worried and anxious due to skin problem? ❑ No ❑ Yes:
Trouble sleeping due to skin? ❑ No ❑ Yes:	Fever or Chills? ❑ No ❑ Yes:
History of weight loss? ❑ No ❑ Yes:	Are you pregnant? ❑ No ❑ Yes:
Activity level restricted? ❑ No ❑ Yes:	Are you breastfeeding? ❑ No ❑ Yes:

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? _____

Patient Primary Physician: _____

Please list any prescription and over-the-counter medications (with dosage and frequency) you are currently taking:

Medication:	Dosage:	Directions:

List the pharmacy that you use the most, including mail orders:_____

Please list any prescription and/or over-the-counter medications you are ALLERGIC to and the reaction you had when you took them: _____

PROVIDER INITIALS _____ DATE: _____

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	Diabetes	❑ No	❑ Yes
Eczema	❑ No	❑ Yes	High Cholesterol	❑ No	❑ Yes
Psoriasis	❑ No	❑ Yes	Excessive Bleeding	❑ No	❑ Yes
Asthma	❑ No	❑ Yes	High Blood Pressure	❑ No	❑ Yes
Allergies / Hay fever	❑ No	❑ Yes	Peptic Ulcer Disease	❑ No	❑ Yes
Heart Problems	❑ No	❑ Yes	Kidney Problems	❑ No	❑ Yes
Hepatitis	❑ No	❑ Yes	Autoimmune Disorder	❑ No	❑ Yes
Allergy to sun	❑ No	❑ Yes			

What surgeries have you had in the past?_____

Any other medical problems not listed above?_____

Social & Behavioral History

Occupation: _____

Marital status: ❑ Single ❑ Married ❑ Partnered ❑ Separated ❑ Divorced ❑ Widowed

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

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

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

Amount of sun exposure: ❑ Mild ❑ Moderate ❑ Severe

PROVIDER INITIALS _____ DATE: _____