SINGER DERMATOLOGY
29355 Northwestern Highway, Suite 302 Southfield, MI. 48034
248-228-2990 phone 248-281-1764 fax
Robert Singer, M.D.
Daneen Locke, PA-C. Lisa Pilley, PA-C. Jenny Pateryn, PA-C. Dana Vered, NP

NEW PATIENT HISTORY FORM

- Name: _____
- Main Reasons for coming to the office: _____

_____

- Location of Problem(s): _____
- Please briefly describe the problem(s):

_____

- How severe is your problem (please circle): mild / moderate / severe

- Duration of Problem (when did it first start?): _____
- Does it itch ? yes / no
- Is it painful ? yes / no
- Is it growing or changing? yes / no

- Select any of the following medical conditions that you currently have:

☐ Anxiety	☐ Hearing Loss
☐ Arthritis	☐ HIV/AIDS
☐ Asthma	☐ Hypercholesterolemia
☐ Atrial Fibrillation (Irregular Heartbeat)	☐ Hyperthyroidism
☐ BPH (enlarged prostate)	☐ Hypothyroidism
☐ Cerebrovascular Accident (Stroke)	☐ Inflammatory Disease of the Liver
☐ COPD (chronic obstructive lung disease)	☐ Leukemia
☐ Depressive Disorder	☐ Lymphoma
☐ Diabetes Mellitus	☐ Malignant Tumor of the Lung
☐ Disease caused by Covid-19	☐ Malignant Tumor of the Breast
☐ Elevated Blood Pressure	☐ Malignant Tumor of the Colon
☐ End Stage Renal Disease	☐ Malignant Tumor of the Prostate
☐ Epilepsy	☐ Radiation Therapy
☐ GERD (reflux)	☐ Transplantation of the Bone Marrow

☐ Other (please explain) _____

☐ **NONE**

Please do not leave anything blank. If something does not apply please put N/A.

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● Name: _____

● Please list any prior surgeries and procedures (don't forget any heart, joint, skin procedures, C-section, tubal ligation, and hysterectomy).

_____

_____

FOR FEMALES ONLY:

Date of last Menstrual Period _____

Last Pelvic Exam _____

Last Mammogram _____

Last PAP smear _____

Number of Children (if applicable) _____

For all patients (again);

Birth Weight _____

Birth Age (gestation if known, usually 38-42 weeks, unless you were premature) _____

Any maternal illnesses during pregnancy? If yes, explain: _____

● **Have you had any of the following skin conditions** ?

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Asteatosis Cutis (Dry Skin)
- ☐ Basal Cell Skin Cancer
- ☐ Precancerous (atypical/dysplastic) Moles
- ☐ Eczema
- ☐ Asthma
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Scalp itching/flaking
- ☐ Psoriasis
- ☐ Squamous cell skin cancer
- ☐ Sunburn (2nd or 3rd degree – with blisters)
- ☐ Other (please explain) _____

Do you wear Sunscreen? _____ yes _____ no
If yes, what SPF? _____
Do you tan in a tanning salon? _____ yes ____ no

Please do not leave anything blank. If something does not apply please put N/A.

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● Name: _____

● Family History

Do you have a family history of Melanoma?

O yes O no

If yes, which relative?

- ☐ Mother
- ☐ Father
- ☐ Sister
- ☐ Brother
- ☐ Daughter
- ☐ Son
- ☐ Uncle
- ☐ Other _____
- ☐ Aunt
- ☐ Nephew
- ☐ Niece
- ☐ Grandmother
- ☐ Grandfather
- ☐ Grandson
- ☐ Granddaughter

● Please list your medications and supplements (and the month and year you began each one. This is very important. Don't forget OTC products like aspirin, ibuprofen, Tylenol. Also put in any medications you have stopped within the last 6 months). Please let us know the dose and frequency you are taking these!

_____

_____

_____

_____

_____

● Are you allergic to any medications? yes / no

If so, please list the date or year you had the reaction and what kind of symptoms you had, such as rash, itching, hives, shortness of breath, nausea, etc.

_____

_____

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● Name: _____

● Do you smoke, vape, or chew tobacco: yes / no / quit

● Do you drink alcohol: yes / no / quit

If you drink, how many drinks per day? ____<1 _____ 1-2 _____ 3 or more

● Do you drive (if age appropriate) ____ yes ____ no

If so, do you drive at night? ____ yes _____ no

● How often do you exercise?

___ never ____ once a day ___ several times per day ___ a few times a week ___ a few times a month

● What is your caffeine use?

___ never ____ once a day ___ several times per day ___ a few times a week ___ a few times a month

● Do you feel safe at home ____ yes ____ no. Please explain if no _____

Do you have any family history of diabetes, heart disease, cancer, autoimmune disease, psoriasis or other skin condition?

If yes, please explain: _____

_____

_____

_____

_____

_____

Please continue to page 5

Please do not leave anything blank. If something does not apply please put N/A.

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● Name: _____

Do you have ? (please circle):

● Do you have a pacemaker?	yes / no	If yes, explain _____
● Do you have a defibrillator?	yes / no	If yes, explain _____
● Do you have an artificial heart valve?	yes / no	If yes, explain _____
● Do you have artificial joints within the past two years ?	yes / no	If yes, explain _____
● Do you premedicate before procedures?	yes / no	If yes, explain _____
● Do you allergy to adhesive?	yes / no	If yes, explain _____
● Do you have allergy to topical Antibiotic ointments?	yes / no	If yes, explain _____
● Are you on blood thinners ?	yes / no	If yes, explain _____
● Do you have problems with bleeding?	yes / no	If yes, explain _____
● Do you get a rapid heartbeat with epinephrine (dentist, etc) ?	yes / no	If yes, explain _____
● Do you get GI upset with antibiotics	yes / no	If yes, explain _____
● Do you have allergy to lidocaine?	yes / no	If yes, explain _____
● Do you have anxiety (especially at a doctor's office) ?	yes / no	If yes, explain _____
● Do you have a changing mole ?	yes / no	If yes, explain _____
● Do you have a rash?	yes / no	If yes, explain _____
● Do you have problems with healing (scars/keloids) ?	yes / no	If yes, explain _____
● Do you have nausea or upset stomach?	yes / no	If yes, explain _____
● Do you have chest pain ?	yes / no	If yes, explain _____
● Do you have a cough?	yes / no	If yes, explain _____
● Do you have fever or chills ?	yes / no	If yes, explain _____
● Do you have headaches?	yes / no	If yes, explain _____
● Do you have joint pain?	yes / no	If yes, explain _____
● Do you have a history of MRSA?	yes / no	If yes, explain _____
● Do you have a immunosuppression meaning recent chemotherapy or medications which lower the immune system?	yes / no	If yes, explain _____
● Do you have depression?	yes / no	If yes, explain _____
● Do you have a recent history of a fever >100.4 F or 38 C?	yes / no	If yes, explain _____
● Do you have a recent history of a exposure to COVID-19?	yes / no	If yes, explain _____
● Do you have a recent diagnosis of COVID-19?	yes / no	If yes, explain _____

Please do not leave anything blank. If something does not apply please put N/A.

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● Name: _____

Females only (this applies to all females age 10 and older):

- **Are you pregnant? yes / no If yes, explain _____**
- **Are you planning a pregnancy? yes / no If yes, explain _____**
- **When is the last date of your period (or last period if menopausal) ___/___/_____**
- **If you are avoiding pregnancy, what method are you using, such as birth control pills, IUD, abstinence, Depo-Provera, condoms, or other: _____**
- **Are you breastfeeding? yes / no If yes, explain _____**

*****FOR ALL AGAIN:*****

● Who referred you to this office?

_____

● Please list the name, phone, and fax (if known) of any doctors who should receive a note about today's visit

_____

_____

_____

Please list the name, address and phone number of your preferred pharmacy:

_____

Please do not leave anything blank. If something does not apply please put N/A.