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
Bryan Sofen, M.D. Amber Roberts, PA-C. Marianne Harbut, PA-C.

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

Please list any medical conditions you have:

____

____

____

____

Please list any surgeries or procedures you have had in the past, or any upcoming in the next 3 months:

____

____

____

____

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

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● Name: ___________________________

Please list any skin conditions or skin cancers you have had in the past, along with treatments:

____

____

____

____

Please list any family history of melanoma or any other skin condition:

____

____

● 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!

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● Name: ___________________________

● 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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____

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

If yes, please explain: ____

____

____

____

____

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 year? yes / no If yes, explain ____________________
● Do you premedicate before procedures? yes / no If yes, explain ____________________
● Do you have an 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 ____________________

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● Name: ___________________________

● Do you have allergy to lidocaine? yes / no If yes, explain _____________________
● Do you have problems with healing (scars/keloids) ? 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 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 _____________________

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

● Are you pregnant? yes / no If yes, when are you due: _______________

● 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 _________________

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.