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. Dana Vered, N.P. Marianne Harbut, PA-C
Bryan Sofen, M.D. Amber Roberts, PA-C. Amanda Young, PA-C.

NEW PATIENT HISTORY FORM

Name: _____

Main Reasons for coming to the office: _____

_____

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

Duration of Problem (when did it first start?): _____

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

_____

_____

_____

_____

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

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Name: _____

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!

_____

_____

_____

_____

_____

_____

_____

_____

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

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Name: _____

Females only (this applies to all females ages 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:

_____

THANK YOU FROM SINGER DERMATOLOGY

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