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UNIVERSAL DERMATOLOGY, PLLC

ROCHESTER SKIN LYMPHOMA MEDICAL GROUP, PLLC

New Patient Registration Information

Name: _____ **Date of Birth:** __/__/____

Address: _____

Home Phone: (____) _____ Preferred? ☐ Messages? ☐

Mobile Phone: (____) _____ Preferred? ☐ Messages? ☐

Work Phone: (____) _____ Preferred? ☐ Messages? ☐

Email: _____

Emergency Contact: _____ **Phone:** (___) _____

Primary Care Physician: _____ **Referring Physician:** _____

Insurance Provider/Number: _____ **Effective date:** _____

Policy Holder: _____ **Address:**_____

Do you know a recent: Weight ____ **Height** ____ **Blood Pressure** ____

Medications:_____

Allergies:_____

Past Medical History (check all that apply):

- ☐ Acid Reflux
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ AFib (Irregular Heartbeat
- ☐ Bone Marrow Transplant
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ CTCL
- ☐ Depression
- ☐ Hearling Loss
- ☐ HIV
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ High Blood Pressure (Hypertension)
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Mycosis Fungoides
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Other _____

Prior Surgeries (check all that apply):

- ☐ Appendix
- ☐ Bladder
- ☐ Breast, Lumpectomy
- ☐ Breast, Mastectomy
- ☐ Colon, Diverticulitis
- ☐ Colon, Inflammatory Bowel Disease
- ☐ Colon, Cancer
- ☐ Gallbladder
- ☐ Heart, Valve Replacement
- ☐ Heart, Bypass
- ☐ Heart, Transplant
- ☐ Joint Replacement
- ☐ Kidney, Transplant
- ☐ Kidney, Nephrectomy
- ☐ Liver, Transplant
- ☐ Testicles
- ☐ Uterus
- ☐ Other:_____

Skin Disease History (check all that apply):

- ☐ Abnormal Moles (Dysplastic Nevi
- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Blistering Sunburns : How Many ☐
- ☐ Eczema
- ☐ Hay Fever
- ☐ Psoriasis
- ☐ Basal Cell Carcinoma (BCC) Where:_____ When:_____
- ☐ Squamous Cell Carcinoma (SCC) Where:_____ When:_____
- ☐ Melanoma (MM) Where:_____ When:_____
- ☐ Merkel Cell Carcinom Where:_____ When:_____

Uses Sunscreen ☐ What SPF?_____ Current/Past Tanning Bed Use? ☐

Family History (chronic illnesses in grandparents/parents/siblings/children):

_____

Family History of Skin Cancer (BCC, SCC) ☐ **Family History of Melanoma** ☐ Who?_____

Social History (check where appropriate):

Occupation:_____

Smoking: Current ☐ PPD:_____ Never ☐ Former ☐ Year Quit:_____

Alcoholic Beverages(Beer, Wine, Cocktails) ☐ # drinks per day _____

Drives in the daytime ☐ Drives in the night ☐ Exercise ☐ How Often:_____

Caffeine use ☐ How often?_____

Comments: