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 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:

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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 skin condition?	s, heart disease, cand	cer, autoimmune disease, psoria	asis, or other
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	yes / no	If yes, explain	
epinephrine (dentist, etc.)?			<u> </u>
Do you have allergy to lidocaine?	yes / no	If yes, explain	
Do you have problems with		If yes, explain	
healing (scars/keloids)?			

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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