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Saginaw Bay Dermatology New Patient Medical History

Saginaw Bay Dermatology
106 East Main St.
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Phone: (989) 883-3800
Fax: (989) 883-9131

Please answer all questions and bring this with you on the day of your appointment. If you provide your email address you may also have appointment and laboratory reminders sent to you via email.

Name: _____

Address: _____

City: _____ State: _____ Zipcode: _____

Phone (home): _____ Phone (work/other): _____

Email Address: _____ Birthdate: _____ Gender: _____

Emergency Contact – Must live in a separate residence or have a different phone number.

Name: _____ Phone Number (Home): _____

Relationship: _____ Phone Number (Work): _____

Insurance Information (if other than yourself) – Please bring your insurance cards with you.

All of the information below is required to properly bill your insurance company. If you do not provide all of the information requested, including the subscriber social security numbers, you will be billed for your visit.

Primary Insurance: _____ Secondary Insurance: _____

Subscriber Name: _____ Subscriber Name: _____

Subscriber Birth Date: _____ Subscriber Birth Date: _____

Subscriber SSN: _____ Subscriber SSN: _____

Office Visit Copay: _____ **** Your co-pay is due the day of your appointment ****

Referring / Family Physician

If your insurance is an HMO, then you require a referral from your family physician. If you do not have the required referral, you will have to pay for your visit (at the time of your visit) or you will not be seen.

Has your family doctor approved a referral? YES NO

Family Physician: _____ Phone Number: _____

Referring Physician: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Laboratory (if you need to use a specific one)

Lab Name: _____

NAME: _____

Birth Date: _____

REASON YOU ARE HERE: _____

MEDICATION HISTORY- List all medications that you currently take. *Include drugs like, Motrin, Tylenol, Vitamins, herbals, etc. Please bring all your medicines to your visit.*

Drug	Dose	Reason?	Drug	Dose	Reason?

MEDICATION ALLERGIES: NO YES - list medication allergies below

Medication	Type of Reaction	Medication	Type of Reaction

PAST MEDICAL HISTORY – Check only those that apply

ALLERGY/IMMUNO	CARDIO-VASCULAR	SKIN	PSYCHIATRIC
food allergy <input type="checkbox"/>	high cholesterol <input type="checkbox"/>	acne <input type="checkbox"/>	anxiety <input type="checkbox"/>
hay fever <input type="checkbox"/>	high triglycerides <input type="checkbox"/>	eczema <input type="checkbox"/>	depression <input type="checkbox"/>
lupus <input type="checkbox"/>	hypertension <input type="checkbox"/>	herpes <input type="checkbox"/>	NEUROLOGIC
rheumatoid arthritis <input type="checkbox"/>	heart attack <input type="checkbox"/>	keloids <input type="checkbox"/>	stroke <input type="checkbox"/>
scleroderma <input type="checkbox"/>	blood clots / DVT <input type="checkbox"/>	melanoma <input type="checkbox"/>	dementia <input type="checkbox"/>
vasculitis <input type="checkbox"/>	GI/GU	psoriasis <input type="checkbox"/>	MUSCULO-SKEL
EYES/NOSE	hemorrhoids <input type="checkbox"/>	skin cancers <input type="checkbox"/>	arthritis <input type="checkbox"/>
cataracts <input type="checkbox"/>	hiatal hernia <input type="checkbox"/>	warts <input type="checkbox"/>	Fractures <input type="checkbox"/>
glaucoma <input type="checkbox"/>	hepatitis <input type="checkbox"/>	ulcers <input type="checkbox"/>	ENDOCRINE
deafness <input type="checkbox"/>	stomach ulcers <input type="checkbox"/>	BLOOD	diabetes <input type="checkbox"/>
PULMONARY	Renal failure / dialysis <input type="checkbox"/>	anemia <input type="checkbox"/>	hypothyroid <input type="checkbox"/>
asthma <input type="checkbox"/>	kidney stones <input type="checkbox"/>	transfusions <input type="checkbox"/>	Hyperthyroid <input type="checkbox"/>
emphysema <input type="checkbox"/>	OTHER		
TB <input type="checkbox"/>			

SOCIAL HISTORY

Do you smoke? **No** **Yes** _____ packs/day for _____ years

Do you drink alcohol? **No** **Yes** _____ drinks/day

Do you use recreational drugs? **No** **Yes** ___ Injectable ___ Oral ___ Inhaled

Have you ever had an STD? **No** **Yes** (sexually transmitted disease)

Do you work? **No** **Yes** Occupation: _____

PAST SURGICAL HISTORY – Check all that apply

SURGERY	YES	NO	WHEN
CABG (Bypass)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gallbladder Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Appendectomy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Valve Repair	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Valve Replacement	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other: _____			_____

SURGERY	YES	NO	WHEN
Hip replacement - Right	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hip replacement - Left	<input type="checkbox"/>	<input type="checkbox"/>	_____
Knee replacement - Right	<input type="checkbox"/>	<input type="checkbox"/>	_____
Knee replacement – Left	<input type="checkbox"/>	<input type="checkbox"/>	_____
Iliostomy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Colectomy including partial	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other: _____			_____

Do you need antibiotics before procedures?

YES NO

FAMILY HISTORY – Check all that apply

DISEASE	Father	G. Father	G. Mother	Mother	G. Father	G. Mother	Sister	Brother
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DISEASE	Father	G. Father	G. Mother	Mother	G. Father	G. Mother	Sister	Brother
Basal Cell Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squamous Cell Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Melanoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SYSTEMS REVIEW – Check all that apply

GENERAL

- appetite change
- chills
- dizziness
- excess thirst
- fatigue
- fever
- night sweats
- nausea / vomiting
- weight change

EYES

- dry eyes
- light sensitive
- yellow eyes

ENT

- bleeding gums
- dry mouth
- mouth ulcers
- sinus drainage

CARDIO-VASCULAR

- chest pain/tight
- heart murmur
- leg swelling
- palpitations

GI

- Black/ bloody stools
- constipation
- diarrhea
- heartburn
- stomach pain
- trouble swallowing

GU

- blood in urine
- discharge
- painful urination

ENDOCRINE

- abnormal hair growth
- abnormal hair loss
- flushing
- menstrual problems

MUSC-SKEL

- back pain
- joint pains
- joint swelling
- leg cramps

NEUROLOGIC

- blackouts
- headaches
- Numbness

PSYCHIATRIC

- memory problems
- panic attacks
- suicide thoughts
- suicide attempt

PULMONARY

- shortness of breath
- wheezing

OTHERS

- x-ray therapy
- chemotherapy

ALLERGY/IMMUNO

- watery eyes
- Sneezing

HEMATOLOGIC

- bleeding tendencies
- easy bruising
- swollen lymph nodes

SKIN

- blisters
- itching
- lesions/growths
- nail changes
- pigment loss
- sun sensitivity
- changing moles