THE UNIVERSITY OF KANSAS PHYSICIANS

Department of Internal Medicine – Dermatology

Welcome to our practice. As a new patient, we will discuss your health in detail. To help us in these discussions, please fill out the information below to the best of your ability.

Name: _______________________________
KUMC #: _____________________________
Date: _____________ **DOB**: _______________

Reason for today's visit____

Please list all allergies:____

Have you ever used a tanning bed (how often)?____

Do you use tobacco? YES NO Type_______________________ Frequency______________Quit?____________

Alcohol use? YES NO Are you pregnant? YES NO Are you trying to become pregnant? YES NO

Do you need antibiotics when having dental work? YES NO

Do you get thick scarring from surgery? YES NO

Do you have a history of skin cancer? YES NO If Yes, what type? Basal Cell Squamous Cell Melanoma

Have any blood related family members had skin cancer? YES NO

If yes, what type? Basal Cell Squamous Cell Melanoma Unknown
If yes, whom?____

Do you have any other type of cancer? YES NO If yes, what type? ___________________________________

Do you have HIV/AIDS? YES NO

Have you had an organ transplant? YES NO Type:____

What is your occupation?____

Would you like to sign up for MyChart? YES NO

(All of our lab/pathology results will now be released through MyChart in the future for your convenience.)

Review Medication list provided or please list any new medications you are taking:

____
____
____
____

Preferred Pharmacy:____

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ARE YOU CURRENTLY EXPERIENCING ANY OF THESE SYMPTOMS?

Appetite Change	YES	NO	Blood in stool	YES	NO
Sweating (diaphoresis)	YES	NO	Diarrhea	YES	NO
Fever	YES	NO	Nausea	YES	NO
Unexpected weight change	YES	NO	Vomiting	YES	NO
Congestion	YES	NO	Difficulty urinating	YES	NO
Mouth sores	YES	NO	Blood in urine (hematuria)	YES	NO
Sore throat	YES	NO	Joint pain (arthralgia)	YES	NO
Eye itching	YES	NO	Muscle pain	YES	NO
Eye pain	YES	NO	Skin color change	YES	NO
Eye redness	YES	NO	Pale skin (pallor)	YES	NO
Visual Disturbances	YES	NO	Rash	YES	NO
Cough	YES	NO	Wound	YES	NO
Shortness of breath	YES	NO	Dizziness	YES	NO
Leg swelling	YES	NO	Seizures	YES	NO
Rapid heartbeat (palpitations)	YES	NO	Bruise/bleed easily	YES	NO
Abdominal pain	YES	NO	Confusion	YES	NO
Depression (dysphoric mood)	YES	NO	Nervous/anxious	YES	NO