Heartland Skin Center
Our specialty is you

Jennifer A. Wolf, PA-C

New Patient History Form

Also for established patients seen by Heartland Skin Center 1 year ago or more

Please fill out the following information if:
1. You are a new patient to *Heartland Skin Center*.
2. If it has been 1 year or longer since you have seen by *Heartland Skin Center*.

1) Personal information. Please enter in your name and the other information below.

Date of birth: Age: Gender: ☐ M ☐ F Date:

Last name, First name MI, Degree, Suffix

2) Please list your allergies

Lidocaine ☐yes/☐no Explain _____
Epinephrine ☐yes/☐no Explain _____
Latex ☐yes/☐no Explain _____
Other allergies ☐yes/☐no Explain _____
_____
_____

☐ I have no known drug allergies

3) Please list your **dermatology-related medications** and why you are taking them (**names and dosages**).
Example 1: Doxycycline 100mg pills two times per day Example 2: Triamcinolone 0.1% cream applied to hands two times per day as needed for rash

☐I am not taking dermatology-related medications
_____
_____
_____

4) Have you had the pneumonia vaccine? ☐Yes ☐No

5) Do you use alcohol? ☐Yes ☐No
If yes, how many per week or occasion? _____ week/occasion (circle one)

6) Do you currently use tobacco products? ☐Yes ☐No If yes, was cessation counseling provided?

To be filled out by Medical Assistant.
☐**Yes Signature:** _____
☐**No Signature:** _____

7) Past medical history
Please check if you have or are being treated for any of the following:

☐yes/☐no Basal cell carcinoma ☐yes/☐no Squamous cell carcinoma
☐yes/☐no Melanoma ☐yes/☐no Hepatitis B or C
☐yes/☐no HIV/AIDS ☐yes/☐no Diabetes
☐yes/☐no High blood pressure ☐yes/☐no Immunosuppression (suppressed immune system)
Other medical conditions:_____
_____
_____