LEHIGH VALLEY DERMATOLOGY ASSOCIATES, LTD.

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Dear New Patient,

Welcome to our practice. Although the following forms may seem complicated, they can help us better understand your skin condition and possible relationship to your general medical health.

Simply do the best you can with these forms. Our assistants can help you with specific questions when you are in the exam room.

Your appointment is very important to you and to us. During each day, we have a limited number of appointments available to accommodate all our patients. If you are not able to keep your appointment, we require notice at least 24 hours before your scheduled appointment so that we can attempt to fill the spot with another patient **If notice of cancellation is not given at least 24 hours in advance of your appointment, you will be charged a fee of $135.00.** That fee will be charged to your credit card that is on file with the office. Payment of this fee is required before you can reschedule your appointment. By signing below, you acknowledge notice of our cancellation policy and agree to abide by its terms.

Sincerely,

David B. Vasily, M.D.

Stephen C. Senft, M.D.

Michelle Ramsberger, PA-C

Sarah Hartman, PA-C

Lianne McGinn-Bunn, PA-C

Account # _____

DERMATOLOGIC MEDICAL HISTORY

Patient: _____ Age: _____ DOB: _____ Date: _____

Family Doctor: _____ Referring Physician (if any) _____

Leave message on answering machine: _____ yes _____ no

Chief Complaint (reason for today's visit). If you can, provide additional information about today's complaint including duration prior to treatment and itching. _____

_____

_____

Allergies: ____ hayfever ____ latex ____band-aids ____ Betadine ____ Neosporin ____ lidocaine

List all medication allergies (lidocaine, sulfa, penicillin) _____

_____

_____

Surgical History - especially heart valve, pacemaker, and joint replacement surgery. _____

_____

List all medications you are currently taking:

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Do you take aspirin? Yes ____ No ____
Do you take prophylactic antibiotics for dental work: Yes ____ No ____ If yes, why? _____

Medical History (include diabetes, high blood pressure, skin cancer, internal cancer):

_____

_____

Family History _____ psoriasis _____ eczema _____ skin cancer _____ melanoma

Social History: Occupation _____
Do you smoke cigarettes?: ___ Yes ___ No Duration _____ Do you consume alcohol? ___ Yes ___ No

Preferred Pharmacy:

Local Pharmacy: _____

Mail Order: _____

Completed by: ____ Patient
____ Medical Assistant _____
Initials

Reviewed by Physician/Physician Assistant _____
Date

_____
Signed by Patient Date

_____
Reviewed by Date

Itching or dryness	___	___
Hair or nail changes	___	___
HEENT		
Visual changes	___	___
Glaucoma	___	___
Loss of hearing	___	___
Ringing in ears	___	___
Sinus problems	___	___
Sore throat/hoarseness	___	___
NERVOUS SYSTEM		
Convulsions/epilepsy	___	___
Dizziness/fainting	___	___
Psychiatric treatment	___	___
RESPIRATORY		
History of tuberculosis	___	___
History of emphysema	___	___
History of asthma/hay fever	___	___
Persistent cough/cold	___	___
ENDOCRINE/IMMUNOLOGY		
Diabetes	___	___
Thyroid condition/goiter	___	___
Arthritis/rheumatism	___	___
Other	___	___
URINARY		
Kidney disease	___	___
Increase in frequency in urination (night)	___	___
Burning on urination	___	___
Urethral discharge	___	___
Bloody urine	___	___
Shortness of breath	___	___
Swelling of ankles	___	___
High blood pressure	___	___
Other heart problems	___	___
DIGESTIVE SYSTEM		
History of hepatitis	___	___
History of jaundice	___	___
History of ulcers	___	___
Black, blood or pale stools	___	___
BLOOD		
Bruise easily	___	___
Anemia	___	___
Frequent nose bleeds	___	___
REPRODUCTIVE		
Irregular menses	___	___
Currently pregnant?	___	___
Breastfeeding	___	___
Post-menopausal	___	___
Nipple discharge	___	___
OTHER		
Radiation therapy	___	___
Chemotherapy	___	___

I have either read or been asked and replied to the questions above and have completed them to the beast of my knowledge. I have not omitted any other medical information from my history. I am aware that Lehigh Valley Dermatology Associates Limited are not responsible for medical evaluation of any complaints not related to my skin that have not been attended to by my personal medical physician or primary care physician. I agree to see my primary care physician for any medical conditions I am currently aware of or are detected during medical evaluation that are unrelated to my dermatology condition.

Finally, I understand that doctors encourage a complete skin exam and that refusal to have this exam done could have deleterious effects on my health, including failure to detect skin cancer, melanoma, etc. I also understand that the skin is the largest organ of the body and that, it is impossible for the doctors to be responsible for examining every inch of skin covering my body.

MEDICATION LIST

Name:_____ DOB: _____

ALLERGIES or reactions to medications: ____ Yes ____ No; If yes, list medications: _____

_____

_____

PACEMAKER: ____ Yes ____ No

ARTIFICIAL JOINT: ____ Yes ____ No

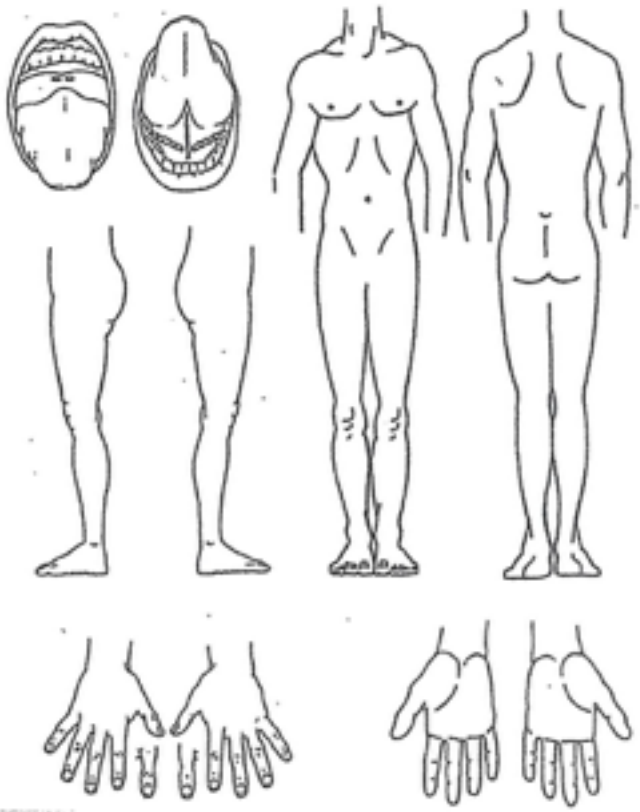
HEART VALVE DISEASE OR REPLACEMENT: ____ Yes ____ No

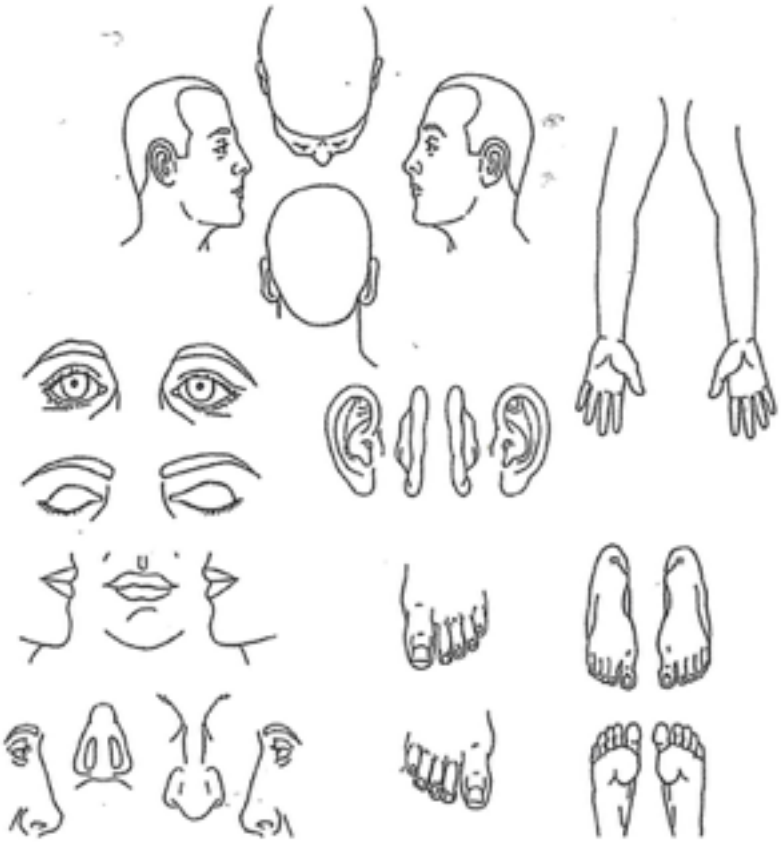
LEHIGH VALLEY DERMATOLOGY ASSOCIATES, LTD.

Name: _____

Vital signs: General Appearance: _____

BP: _____ Pulse:_____ RR: _____





LIST CURRENT MEDICATIONS BELOW. (If no medications, write "**none**," or if attached sheet, write "**see attached**.")

PRESCRIPTION MEDICATIONS
OVER-THE-COUNTER MEDICATIONS (including aspirin, vitamins, herbals)

LOCAL PHARMACY: _____

MAIL ORDER PHARMACY: _____

May message be left on your personal answering machine: ____ Yes ____ No

Medical Assistant: Please check and date.