

YARDLEY DERMATOLOGY ASSOCIATES  
NEW PATIENT PROGRESS FORM

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Occupation: \_\_\_\_\_ Age: \_\_\_\_\_

Medication Allergies: \_\_\_\_\_

Present or Past Medical Problems: \_\_\_\_\_  
\_\_\_\_\_

Previous Surgical Procedures: \_\_\_\_\_  
\_\_\_\_\_

Medications and Supplements: \_\_\_\_\_  
\_\_\_\_\_

Personal History of Skin Cancer (type, location & date): \_\_\_\_\_  
\_\_\_\_\_

Do you have a (circle yes or no):

Artificial joint:           yes    no

Artificial heart valve:    yes    no

Pacemaker:                yes    no

Bleeding condition:       yes    no

Did you ever have (circle yes or no):

Hepatitis/HIV:            yes    no

Heart Valve Infection:    yes    no

Radiation/Xray treatments: yes    no

Family History of Melanoma: yes    no

Relationship: \_\_\_\_\_

Tobacco use: yes no Alcohol/drug abuse: \_\_\_\_\_ Pregnant or planning soon: \_\_\_\_\_

Are you currently experiencing symptoms or problems related to:

asthma/allergies/hayfever

fever/weight loss

eyes/ears/nose

heart

lungs

hormones

stomach/colon

urinary system

muscles/bones

neurological

emotional/mental illness

Reason for visit today (include location on the body of any problem areas, duration of problem, description of symptoms (painful, itching, bleeding) treatments used in past: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_