New Patient Information Form

Name: _____ Date of Birth: _____
MRN: _____
Preferred Pharmacy (Name & City): _____
Email: _____
May we send your pathology or labs to Boyce & Bynum If not, what lab do you prefer? _____ Yes
Yes No (Circle one)
What brings you in today? _____
What is your occupation? _____
How did you hear about us? TV Social Media Friend Other: _____

PAST MEDICAL HISTORY: PLEASE CIRCLE ALL THAT APPLY TO YOU

None
Anxiety
Arthritis
Asthma
Atrial Fibrillation
COPD
Coronary Artery Disease
Depression
Diabetes GERD
Hypertension
Hearing Loss
HIV
High Cholesterol
Thyroid Problems
Leukemia
Lymphoma
Radiation Therapy
Bone Marrow Transplant
Cancer (Please list): _____
Other: _____

PAST SURGICAL HISTORY: PLEASE CIRCLE ALL THAT APPLY TO YOU

None
Gall Bladder Removal
Coronary Artery Bypass
Kidney Transplant
Tubal Ligation
Mastectomy Bilateral, Right, Left
Colectomy
Heart Valve Replacement
Hysterectomy
Mechanical Heath Valve Replacement
Total Hip Replacement Left Right Bilateral
Total Knee Replacement Left Right Bilateral
Organ Transplants (Please List):
_____
_____
_____

SKIN DISEASE HISTORY: PLEASE CIRCLE ALL THAT APPLY TO YOU

None
Acne
Actinic Keratosis
Dry Skin
Basal Cell Carcinoma
Contact Dermatitis due to Poison Ivy
Dysplastic Nevus
Sunburn of the Second Degree
Eczema
Asthma
Hay Fever
Malignant Melanoma
Pruritus of the Scalp
Psoriasis
Squamous Cell Carcinoma
Other: _____

Do you wear sunscreen? Yes No If yes, what SPF? _____
Do you tan in a tanning salon? Yes No
Do you have a family history of Melanoma? Yes No (Circle one)
If so, what member of the family? _____

CLINICAL RESPONSE TO SYSTEMIC MEDICATIONS (Measure 410)
Are you diagnosed with psoriasis? Yes No (Circle one)
What percentage of your body would you say is affected? _____%
Rate the intensity of your itch on a scale from 0 (no itch) to 10 (worst itch imaginable) _____

PSORIASIS & DERMATITIS IMPROVEMENT IN PATIENT-REPORTED ITCH SEVERITY (Measure 485/486)
Are you diagnosed with Psoriasis or Dermatitis (e.g. eczema, atopic dermatitis)? Yes No (Circle one)

ADVANCED CARE PLAN (Measure 47):

1. Do you have a healthcare proxy if you cannot make your own medical decisions?
   Yes No (Circle one)
2. Designee's Name (Optional) _____
3. Designee's Phone Number (Optional) _____

MEDICATIONS: (List all current medications)

DRUG ALLERGIES: (List all drug allergies)

DO YOU HAVE A LATEX ALLERGY? YES or NO (Circle one)

SOCIAL HISTORY: PLEASE CIRCLE ALL THAT APPLY TO YOU

ALCOHOL USE: Less than one drink a day 1-2 drinks a day 3+ drinks a day (Circle one)

TOBACCO USE (Measure 226)

1. What is your smoking status? Smoker Never a Smoker Former Smoker (Circle one)
2. If you are a current smoker, are you looking for tools to quit? Yes No (Circle one)

REVIEW OF SYSTEMS: (Circle ALL that Apply)
NONE HEALING IMMUNE SUPPRESSION JOINT ACHES RASH
FEVER CHILLS PROBLEMS WITH BLEEDING

IMMUNIZATIONS:
Have you had the COVID-19 vaccine? Yes No (Circle one) Date of Last Dose: _____

IMMUNIZATIONS FOR ADOLESCENTS (Measure 394):

1. Has the patient had a meningococcal vaccine (serogroups A, C, W, Y), on or between the patient's 11th and 13th birthdays?
   Yes No (Circle one)
2. Has the patient had tetanus, diphtheria toxoids, and acellular pertussis vaccine (Tdap) on or between the patient's 10th and 13th birthdays?
   Yes No (Circle one)
3. Has the patient had at least two HPV vaccines (with at least 146 days between the two) OR three HPV vaccines on or between the patient's 9th and 13th birthday?
   Yes No (Circle one)

MEDICAL ALERTS: (Circle ALL that Apply)
Allergy to Adhesive Allergy to Lidocaine
Allergy to Topical Antibiotics
Artificial Joint Replacement Blood Thinners
Defibrillator
MRSA
Pacemaker
Require Antibiotics Before Surgery Rapid Heartbeat with Epinephrine Are you pregnant?
Are you currently trying to get pregnant?