TULLAHOMA DERMATOLOGY

1330 Cedar Lane, Suite 700
Tullahoma, TN 37388
Ph. 931-455-7400
F: 931-455-6344

New Patient Forms

*To serve you more efficiently, **please complete these forms and initial and sign all of them** and keep them with you and give to the Medical Assistant when you are in the examination room. Thank you!*

Date: _____/_____/_____ Account Number (staff only) :_____ Age: _____

Name: _____ Date of Birth: _____/_____/_____

Preferred Pharmacy Name & Zip Code: _____

Primary Care Provider: First & Last Name _____City/State_____

Have you received the flu vaccine in the past year? Yes / No (circle answer)

Have you received the Pneumonia vaccine? Yes / No (circle answer)

Circle any of the following medical conditions you currently have:

- Anxiety
- Arthritis
- Atrial Fibrillation
- Bone Marrow Transplant
- BPH
- Breast Cancer
- Colon Cancer
- COPD
- Coronary Artery Disease
- Depression
- Diabetes
- End Stage Renal Disease
- GERD
- Hearing Loss
- Hepatitis
- Hypertension
- HIV/ AIDS
- Hypercholesterolemia
- Hyperthyroidism
- Hypothyroidism
- Leukemia
- Lung Cancer
- Lymphoma
- Prostate Cancer
- Radiation Treatment
- Seizures
- Stroke

Circle and explain any past surgeries on the following:

Heart Yes / No
Heart valve replacement
Stent (PTCA)

Joint Replacement Yes / No
Hip: RT / LT / both
Knee: RT / LT / both

Skin Yes / No
Basal Cell Carcinoma
Melanoma
Squamous Cell Carcinoma

Other surgery: _____

Other surgery: _____

Circle any of the following skin conditions you ever had:

- Actinic Keratosis
- Asthma
- Basal Cell Carcinoma
- Blistering Sunburns
- Dry Skin
- Eczema
- Acne
- Flaking or Itchy Scalp
- Hay Fever / Allergies
- Melanoma
- Poison Ivy
- Precancerous Moles
- Psoriasis
- Squamous Cell Carcinoma

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Do you wear Sunscreen? Yes / No
Do you tan in a Tanning Salon? Yes / No
Do you have a family member with a history of Melanoma? Yes / No If yes, which relative? _____
Have you ever had Melanoma? Yes / No

Current Medication List **(please place one per line, If you have a list, we can make a copy)**

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Medication Allergies **(please place one per line, If you have a list, we can make a copy)**

1. _____ 3. _____
2. _____ 4. _____

Smoking History **(Circle Answer)**

Do you currently smoke? Yes / No Former smoker? Yes / No

Surgical History **(Circle Answer)**

Do you bruise easily? Yes / No
Have you ever had difficulty stopping bleeding? Yes / No
If you have an artificial joint, is it within the past 2 years? Yes / No
Do you have an artificial heart valve? Yes / No
Do you have a pacemaker? Yes / No
Do you have a defibrillator? Yes / No
Do you have an allergy to adhesive? Yes / No
Do you have an allergy to lidocaine? Yes / No

(Female patients only)

Have you been pregnant in the past? Yes / No

Are you currently pregnant or planning to become pregnant? Yes / No

Do you have a Healthcare Proxy? (Someone who can legally make medical decisions on your behalf)

(Please Circle) Yes No If yes, please provide their name and phone number.

Healthcare Proxy name: _____ Phone #:_____

Patient signature: _____ Date: _____/_____/_____

Print patient name: _____