

PATIENT INFORMATION

PLEASE PRINT CLEARLY
DO NOT LEAVE BLANKS

DATE _____

LAST NAME _____ FIRST NAME _____

HOME ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

EMAIL: _____

BIRTHDATE _____ AGE _____

SEX M F MARITAL STATUS M S W D SOC. SEC. # _____

BUSINESS NAME _____

BUSINESS ADDRESS _____ CITY _____

OCCUPATION _____

REASON FOR VISIT _____

REFERRED BY _____ REFERRED DERMATOLOGIST: _____

MEDICAL HISTORY

PLEASE LIST ALL ALLERGIES _____

DATE OF LAST CHECKUP _____

NAME OF YOUR DOCTOR _____

ADDRESS _____

PLEASE LIST ILLNESSES OR INJURIES (begin with most recent) _____

PLEASE LIST ANY CONDITIONS REQUIRING REGULAR VISITS TO A PHYSICIAN _____

PLEASE LIST ANY PREVIOUS SURGERY WITH DATES (Begin with the most recent) _____

ARE YOU PRESENTLY TAKING ANY MEDICATIONS? IF SO, PLEASE LIST WITH DOSAGE AMOUNTS

DO YOU TAKE ASPIRIN? Y N DO YOU USE TOBACCO? Y N DO YOU CONSUME ALCOHOL? Y N
HOW MUCH? _____ HOW MUCH? _____ HOW MUCH? _____

PLEASE CHECK ANY ILLNESSES OR CONDITIONS THAT HAVE HAD:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> FAINTING OR DIZZY SPELLS | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> BLEEDING TENDENCIES | <input type="checkbox"/> FREQUENT INFECTIONS | <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> THYROID DISEASE |
| <input type="checkbox"/> BREATHING PROBLEMS | <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> NERVOUS DISORDER | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> NUTRITIONAL PROBLEMS | <input type="checkbox"/> ULCER DISEASE |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> URINARY TRACT INFECTION |

SIGNIFICANT FAMILY ILLNESSES _____

HAVE YOU RECEIVED A BLOOD TRANSFUSION? YES NO IF SO, WHEN? _____

FOR WOMEN

ONSET DATE OF LAST MENSTRUAL PERIOD _____ REGULAR IRREGULAR

NUMBER OF PREGNANCIES _____

DO YOU TAKE ORAL CONTRACEPTIVES? YES NO

METHOD OF PAYMENT _____

MEDICAL INSURANCE _____

ADDRESS _____

ID NUMBER _____ GROUP NUMBER _____

SECONDARY INSURANCE _____

ADDRESS _____

ID NUMBER _____ GROUP NUMBER _____

YOUR DRUGSTORE _____ PHONE _____

IN CASE OF EMERGENCY, NOTIFY _____ PHONE _____

PATIENT SIGNATURE _____ DATE _____

THANK YOU FOR YOUR COOPERATION