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:

☐ ASTHMA	☐ FAINTING OR DIZZY SPELLS	☐ HIGH BLOOD PRESSURE	☐ STROKE
☐ BLEEDING TENDENCIES	☐ FREQUENT INFECTIONS	☐ KIDNEY DISEASE	☐ THYROID DISEASE
☐ BREATHING PROBLEMS	☐ GLAUCOMA	☐ NERVOUS DISORDER	☐ TUBERCULOSIS
☐ CANCER	☐ HEART MURMUR	☐ NUTRITIONAL PROBLEMS	☐ ULCER DISEASE
☐ DIABETES	☐ HEART DISEASE	☐ RHEUMATIC FEVER	☐ 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