DERMATOLOGY FIRST VISIT **Ref:_______________ INS:______________**

Patient Name ____ Date ________________

Pharmacy Name, Location & Phone Number: ____

Reason for visit: ____

Medical Allergies: _________________________ **Current Medications:** ________________________

___________________________ ___________________________

___________________________ ___________________________

___________________________ ___________________________

___________________________ ___________________________

Do you or your family have a history of any of the following?
(Check only those that apply)

	YOU	FAMILY
Psoriasis	☐	☐
Eczema	☐	☐
Dysplastic moles	☐	☐
Cancer (including skin)	☐	☐
Melanoma	☐	☐
Diabetes	☐	☐
High Blood Pressure	☐	
Heart Problems	☐	
Lung Problems	☐	
Stomach problems	☐	
Kidney problems	☐	
Arthritis	☐	
Tuberculosis	☐	
Hepatitis	☐	
Cosmetic surgery	☐ if yes, when______________	

Are you currently having problems with any of the following?

	YES	NO
General Health: (e.g. fever, weight loss)	☐	☐
Eyes	☐	☐
Ears/Nose/Throat	☐	☐
Heart	☐	☐
Lungs	☐	☐
Stomach/bowels	☐	☐
Kidneys	☐	☐
Arthritis	☐	☐
Headaches/Seizures	☐	☐
Depression/Anxiety	☐	☐
Thyroid	☐	☐
Bleeding Disorder	☐	☐

Social History:
Number of children/age(s) ______ Occupation ___________________ Hobbies/leisure activities _________________
Females: Are you pregnant or planning to become pregnant in the near future? **YES** **NO**
Do you smoke? **YES** **NO** How many packs per day? _______ How many years? _______________
How much alcohol do you drink? _______________________________________

Reviewed ____ Date _____________________
(MD signature)

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