SOUTH END DERMATOLOGY & SKIN CARE

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Patient Identification

Patient Follow-up Questionnaire

Date:_____ **Last Visit Date:** _____

REASON FOR TODAY'S VISIT:_____

_____

Is this a new condition?: ☐ Yes ☐ No

Has this condition been treated before?: ☐ Yes ☐ No

If yes, what was the treatment and was it successful? _____

_____

Any changes in overall health since last visit?: ☐ Yes ☐ No

Pregnancy Status: Yes / No / Considering / Currently Breastfeeding

Preferred Pharmacy Name & Address:_____

Medications:

Current Medications (including dermatological):_____

_____

Any changes to your medications: ☐ Yes ☐ No

If yes, please explain: _____

_____

Allergies

Drug allergies:_____

Environmental / Seasonal Allergies:_____

Patient Signature:_____ Physician Signature:_____