SOUTH END DERMATOLOGY & SKIN CARE

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Patient Identification

PATIENT INFORMATION SHEET

Date:_____ Time: _____ Last Visit Date (if applicable): _____

☐ Check box if no changes since last visit

Referring Physician:_____ Primary Care Physician:_____

Referring Physician Address:_____

Preferred Pharmacy Name & Address:_____

Age:_____ **Occupation:**_____

Hobbies:_____

Habits: Tobacco / Alcohol / Sunscreen _____

Pregnancy Status: Yes / No / Considering / Currently Breastfeeding

REASON FOR TODAY'S VISIT:_____

Past Skin Problems: (circle all that apply)

Skin Cancer (BCC/SCC) / Melanoma / Blistering Sunburns / Abnormal Moles / Psoriasis / Eczema / None

Details:_____

_____

_____

Past Medical & Surgical History: (circle all that apply)

Heart disease / Lung disease / Liver disease / Hepatitis / Kidney Disease / Thyroid / Diabetes / Arthritis / Bleeding Problems / Lupus / HIV / Sexually transmitted diseases / Cancer / Psychiatric illness / None

Details:_____

_____

_____

Family History: (circle all that apply)

Skin cancer / Melanoma / Abnormal moles / psoriasis / Hay fever / Asthma / Eczema / Hair loss / None

Details:_____

_____

_____

Current Medications (including dermatological):_____

_____

_____

Drug allergies:_____

Environmental / Seasonal Allergies:_____

Do you take antibiotics prior to dental procedures: ☐ Yes ☐ No

Patient Signature:_____ Physician Signature:_____