



ADC DERMATOLOGY PATIENT INFORMATION

Date: _____ Referring Physician: _____

Patient Name: _____ Age: _____

Male Female

Reason for visit: _____

Medication Allergies _____

Location of problem and aggravating factors: _____

Please circle yes or no of any symptoms, or conditions you are currently experiencing:

Fever, Weight Loss: YES NO

Nausea/vomiting/diarrhea: YES NO

Eye Tearing, Drainage: YES NO

New skin growths, rashes, moles: YES NO

Bruising, bleeding: YES NO

Past Medical history/Family History/Social History

<u>Disease</u>	<u>Yourself</u>	<u>Family</u>	<u>Disease</u>	<u>Yourself</u>	<u>Family</u>
Acne	_____	_____	High Cholesterol	_____	_____
Asthma/Hayfever	_____	_____	Kidney Disease	_____	_____
Bleeding Disorder	_____	_____	Joint Replacement	_____	_____
Depression	_____	_____	Liver disease/Hepatitis	_____	_____
Diabetes	_____	_____	Psoriasis	_____	_____
Eczema	_____	_____	Recurrent Yeast Infection	_____	_____
Fever Blisters	_____	_____	Skin Cancer	_____	_____
Heart or Renal Transplant	_____	_____	Melanoma	_____	_____
Heart Valve/Murmur	_____	_____	Thyroid Disease	_____	_____

What is your occupation? _____

Do you smoke? Yes ___ No ___ If yes, how much? _____

What outdoor activities do you enjoy? _____

Do you drink alcohol? Yes ___ No ___ How often? _____

Do you wear sunscreen? Yes ___ No ___

Current medications including non-prescription meds and birth control pills _____

Daytime Phone _____ Evening/Cell Phone _____

Preferred Pharmacy _____

Patient Signature _____ Date _____

Physician's Signature _____ Date _____

FEMALE PATIENTS ONLY

Currently Pregnant? YES NO Using Contraceptives YES NO

Breastfeeding? YES NO Date of last menstrual period? _____