MASSACHUSETTS GENERAL HOSPITAL
DERMATOLOGY

MGH/MGHfC Dermatology Service

Pediatric Dermatology New Patient History Form

Print your name:

Print date of birth:

Medical Record Number: *(if known)*

PEDIATRICIAN

Physician Name: _____

Physician Address: _____

City: _____ State: _____ Zip: _____

Telephone Number ( ) _____

Did a physician refer you to the Dermatology Service? ❒ No ❒ Yes ❒ Same as Above

Physician Name: _____

Physician Address: _____

City: _____ State: _____ Zip: _____

Telephone Number ( ) _____

I authorize Dermatology to leave messages on my (please check off):

❒	**Home Phone**	( )	**Email address:**
❒	**Day/Work Phone**	( )	
❒	**Cell Phone**	( )	

PRESENT PROBLEM(S):

What is the purpose of today's visit? _____

PAST HISTORY:

Do you/your child have any medical problems? Please place a ✓ check mark and complete.

Asthma ❒ Seasonal Allergies ❒ Eczema ❒ Heart Disease ❒ Food/Animal Allergies ❒ (Specify type)_____

Other_____

Have you/your child ever had surgery?	❒ NO	❒ YES	(Please list)
Have you/your child ever been hospitalized?	❒ NO	❒ YES	(Please list)
Do you/your child have any heart conditions?	❒ NO	❒ YES	(Please list)
Do you/your child have to take antibiotics before you go to the dentist?	❒ NO	❒ YES	(Why?)
Have you/child ever had a blistering sunburn?	❒ NO	❒ YES	

MEDICATIONS: Do you/your child take any prescription or over-the-counter medications regularly? Please list:

(1) _____ (2) _____ (3) _____

(4) _____ (5) _____ (6) _____

Are you/your child allergic to any medications? ❒ NO ❒ YES If yes, please list: _____

Please Turn Over and Complete Side 2 ➡ ➡ ➡

Patient Label Here

Family History

Are there any diseases that run in your family? ❑ NO ❑ YES If yes, please list:

Do you/does your child have a **personal history** of the	NO	YES	
Melanoma skin cancer	❑	❑	
Basal cell skin cancer	❑	❑	
Squamous cell skin cancer	❑	❑	
Psoriasis	❑	❑	
Eczema	❑	❑	

Does anyone in **your family** have a history of the following?	NO	YES	If yes, which family member? (ex. mother/father/sibling)
Melanoma skin cancer	❑	❑	
Basal cell skin cancer	❑	❑	
Squamous cell skin cancer	❑	❑	
Eczema	❑	❑	
Psoriasis	❑	❑	

SOCIAL HISTORY:

Who lives at home with your child? (siblings and ages)_____

Grade in school _____

Does your child smoke? ❑ **NO** ❑ **YES**

REVIEW OF SYSTEMS: Does your child have any past or current problems with the following?

			Please describe:
GENERAL HEALTH	❑ NO	❑ YES	
EYES	❑ NO	❑ YES	
EARS/NOSE/MOUTH/THROAT	❑ NO	❑ YES	
HEART	❑ NO	❑ YES	
LIVER	❑ NO	❑ YES	
LUNGS	❑ NO	❑ YES	
STOMACH/BOWELS	❑ NO	❑ YES	
KIDNEYS	❑ NO	❑ YES	
HEADACHES/SEIZURES	❑ NO	❑ YES	
PSYCHOLOGICAL DISORDERS	❑ NO	❑ YES	
THYROID/DIABETES	❑ NO	❑ YES	
BLOOD/BLEEDING DISORDER	❑ NO	❑ YES	
FEMALES: ARE YOU PREGNANT?	❑ NO	❑ YES	
PLAN TO BECOME PREGNANT?	❑ NO	❑ YES	

I authorize the Dermatology Service to release medical information to referring physicians.

Patient's Signature **Today's Date** **Physician Signature** **Today's Date**