### Pediatric Dermatology New Patient History Form

Print your name:  
Print date of birth:  
Medical Record Number:  
(if known)

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### PEDIATRICIAN

Physician Name:  
Physician Address:  
City:  
State:  
Zip:  
Telephone Number  

Did a physician refer you to the Dermatology Service?  
- [ ] No  
- [ ] Yes  
- [ ] Same as Above

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Physician Name:  
Physician Address:  
City:  
State:  
Zip:  
Telephone Number  

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I authorize Dermatology to leave messages on my (please check off):  
- [ ] Home Phone  
- [ ] Day/Work Phone  
- [ ] Cell Phone  

Email address:  

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### PRESENT PROBLEM(S):

What is the purpose of today’s visit?  

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### 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:  

- [ ] NO  
- [ ] YES  
(Please list)

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  
(Why?)

Do you/your child have to take antibiotics before you go to the dentist?  
- [ ] NO  
- [ ] YES

Have you/child ever had a blistering sunburn?  
- [ ] NO  
- [ ] YES

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### 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:

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***Please Turn Over and Complete Side 2***  
Revised February 2015
Family History

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

<table>
<thead>
<tr>
<th>Do you/does your child have a personal history of the following?</th>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Melanoma skin cancer</td>
<td>✗</td>
<td>👑</td>
</tr>
<tr>
<td>Basal cell skin cancer</td>
<td>✗</td>
<td>👑</td>
</tr>
<tr>
<td>Squamous cell skin cancer</td>
<td>✗</td>
<td>👑</td>
</tr>
<tr>
<td>Psoriasis</td>
<td>✗</td>
<td>👑</td>
</tr>
<tr>
<td>Eczema</td>
<td>✗</td>
<td>👑</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Does anyone in your family have a history of the following?</th>
<th>NO</th>
<th>YES</th>
<th>If yes, which family member? (ex. mother/father/sibling)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Melanoma skin cancer</td>
<td>✗</td>
<td>👑</td>
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<td>✗</td>
<td>👑</td>
<td></td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>GENERAL HEALTH</th>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>EYES</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>EARS/NOSE/MOUTH/THROAT</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>HEART</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>LIVER</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>LUNGS</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>STOMACH/BOWELS</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>KIDNEYS</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>HEADACHES/SEIZURES</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>PSYCHOLOGICAL DISORDERS</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>THYROID/DIABETES</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>BLOOD/BLEEDING DISORDER</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>FEMALES: ARE YOU PREGNANT?</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>PLAN TO BECOME PREGNANT?</td>
<td>NO</td>
<td>YES</td>
</tr>
</tbody>
</table>

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

Patient’s Signature    Today’s Date    Physician Signature    Today’s Date