841 Franklin Ave, Suite 4, Franklin Lakes, NJ 07417

DERMATOLOGY PATIENT INFORMATION

Patient Name: _____ Age: _____
Date of Birth_____ Male ☐ Female ☐
Daytime Phone _____ Evening/Cell Phone_____
E-Mail Address _____
Preferred Pharmacy and Town _____ Pharmacy Phone _____
Referring Physician: _____ Phone (Referring Physician)_____
Primary Care Physician _____Phone (PCP)_____

Medications: Please list all prescription and non-prescription meds and birth control pills

Medication Allergies _____
Reason for visit: _____
Location of problem?:_____
How Long have you had it?:_____
Any bleeding, itching, or pain? Please describe?_____
Does anything make it better or worse?_____

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

Fever, weight loss: YES NO
Eye tearing, drainage: YES NO
Bruising, bleeding: YES NO
Nausea/vomiting/diarrhea: YES NO
New skin growths, rashes, moles: YES NO

Past Medical history/Family History/Social History

Disease	Yourself	Family	Disease	Yourself	Family
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**	_____	_____
Kidney/Other Transplant	_____	_____	**Melanoma**	_____	_____
Heart Valve/Murmur	_____	_____	Thyroid Disease	_____	_____
Hypertension/High BP	_____	_____	Psychiatric Illness	_____	_____
Pacemaker/Defibrillator	_____	_____	History of Cancer	_____	_____

Other conditions? Please explain_____

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 ___

FEMALE PATIENTS ONLY
Currently Pregnant? YES NO
Breastfeeding? YES NO
Using contraceptives YES NO
Periods are regular? YES NO
Date of last menstrual period?_____

Patient Signature _____Date _____
Physician's Signature _____Date _____