Mazin A. Dhafir, MD *Colleen M. Dhafir, FNP*

Patient Name (please print) _____ **Date** _____

Insurance Plan Company: _____ **Copay** _____

Have you ever seen another dermatologist? : **YES** **NO**

Name of Dermatologist	For what reason
1.	
2.	

Reason for Today's Visit: _____

	What	Where	How Long*(required)	Notes
Problem 1				
Problem 2				
Problem3				
Problem 4				

Female Pregnancy History:

	(Please circle)		How many weeks?	Details
Are you pregnant?	YES	NO		
Breast Feeding?	YES	NO		

Do Have a LATEX Allergy (please circle one): **YES** **NO**

Patient Other Allergies (IF NONE, PLEASE LIST NONE):

1. _____ 4. _____ 7. _____
2. _____ 5. _____ 8. _____
3. _____ 6. _____ 9. _____

Patient Social History:

ALCOHOL

- ☐ Denies alcohol use
- ☐ Admits alcohol use socially
- ☐ Admits alcohol use daily

SUBSTANCE ABUSE

- ☐ Denies substance abuse
- ☐ Admits substance abuse

SMOKING – REQUIRED: Choose 1 of 3 options:

- ☐ Does not smoke
- ☐ Former smoker
- ☐ Current tobacco smoker
- ☐ Current smokeless tobacco use (eg. chew, snuff)

If current or former smoker, please answer the following:

Smoking Status _____

Started _____ Ended _____

Patient Exposure History (are you exposed to any of the following):

	(Please circle)		Please Explain
Fumes	YES	NO	
Chemicals	YES	NO	
Radiation	YES	NO	
Heat	YES	NO	
Cold	YES	NO	
Other (please list)			

→ **(OVER)**

Animal Exposure: **Please List/Explain**

1. Do you have any indoor pets?_____
2. Do you have contact with farm animals?_____

Patient Past Surgeries/Hospitalizations (IF NONE, PLEASE LIST NONE):

Surgery/Hospitalization	When/Physician	Notes
1.		
2.		
3.		
4.		
5.		
6.		

Patient Current Medications – Please List Over-the-Counter Medications Also (IF NONE, PLEASE LIST NONE):

1. _____ 4. _____ 7. _____
2. _____ 5. _____ 8. _____
3. _____ 6. _____ 9. _____

Over-the-Counter Medications (please list): _____

_____

Patient Medical History (check all that apply):

- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Blood Transfusions
- ☐ Cancer
- ☐ Diabetes
- ☐ Eczema
- ☐ Hay Fever
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Hives
- ☐ Other Suspicious Lesions
- ☐ Premalignant Actinic Keratosis
- ☐ Psoriasis
- ☐ Skin Ulcers
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ **NONE**

Patient Family History (please indicate mother, father, brother, sister, etc.):

- ☐ _____ Asthma
- ☐ _____ Diabetes
- ☐ _____ Hay Fever
- ☐ _____ Heart Disease
- ☐ _____ High Blood Pressure
- ☐ _____ Malignant Melanoma
- ☐ _____ Other Cancer
- ☐ _____ Skin Cancer
- ☐ _____ **NONE**

Other/Remarks: _____

Medical History Verification: **Patient or Parent/Guardian** **Date**

- **All information provided above is accurate and complete to the best of my knowledge**

Signature _____