



NEW PATIENT/PRE-OPERATIVE QUESTIONNAIRE

PRIMARY CARE DR:
DR'S ADDRESS:

DR'S TELEPHONE #:
DR'S FAX #:

DID A DR. SEND YOU TO US FOR A CONSULTATION? Yes No IF YES, please fill out this section:

PRIMARY CARE DR:
DR'S ADDRESS:

DR'S TELEPHONE #:
DR'S FAX #:

SEND PRESCRIPTIONS ELECTRONICALLY TO PHARMACY? Yes No

PHARMACY NAME:
PHARMACY CROSS STREET:

PHARMACY PHONE #:

CURRENT MEDICATIONS (INCLUDE HERBS/VITAMINS):

Table with 3 columns: Allergy Type, Yes, No. Rows include Latex, Tape, Ointment, Penicillin.

MEDICATION ALLERGIES (INCLUDE TOPICALS):

REASON FOR VISIT (Please mark on diagram on back also):

LOCATION OF PROBLEM:
DURATION OF PROBLEM:
TRIGGERS OF PROBLEM:
PREVIOUS TREATMENTS:

Table with 3 columns: Use/Status, Yes, No. Rows include DO YOU CURRENTLY USE: Sunscreen, ARE YOU PREGNANT OR BREAST FEEDING?

DO YOU HAVE NOW OR HAVE YOU HAD A HISTORY OF ANY OF THE FOLLOWING CONDITIONS?

Table with 3 columns: Condition, Yes, No. Rows include Cardiovascular, Respiratory, Endocrine, Psychiatric.

Table with 3 columns: Condition, Yes, No. Rows include Gastroenterology, Genitourinary, Allergic, Neurologic, Skin.

Table with 3 columns: Condition, Yes, No. Rows include Musculoskeletal, Eyes, Head/Ears/ Nose/ Mouth, Hematologic.

Table with 3 columns: Use, Yes, No. Rows include DO YOU CURRENTLY USE: Aspirin, Plavix/Pradaxa/Xarelto/Aggrenox, Coumadin/Other Anti-Coagulants, Advil/Ibuprofen, Tobacco.

Table with 3 columns: Use, Yes, No. Rows include Vitamin E, Retinoids, Ginko Biloba/Herbs, Implantable Medical Devices, Alcohol.

Table with 3 columns: Family History, Yes, No. Rows include ANYBODY IN YOUR FAMILY WITH: Melanoma, Asthma, Eczema, Lupus, Autoimmune disorders.

PATIENT SIGNATURE:

REVIEWED BY:

Patient Identification box

PLEASE MARK THE AREAS RELATING TO YOUR SKIN PROBLEM BELOW:

