Clark Laser & Cosmetic Dermatology

New Patient History Form

Patient Name: _____ Date of Birth: _____/_____/_____

Mailing Address: _____

E-mail address: _____

PRIMARY CARE PHYSICIAN:

Physician Name: _____

Physician Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____

Did a physician refer you to Clark Laser & Cosmetic Dermatology? □ YES □ NO

□ Same as above

Physician Name: _____

Physician Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____

I authorize Dr. Clark and staff to leave messages on my (please check off):

□ Home Phone (_____)_____

□ Day/ Work Phone (_____)_____

□ Cell Phone (_____)_____

PRESENT PROBLEM(S):

What is the purpose of your visit today? _____

_____

PAST HISTORY:

Do you have any medical problems? Please place a ✓ (check mark) and complete.

Diabetes □ Asthma □ Liver Disease □ Hay Fever □ High Blood Pressure □

Cancer □ (specify type) _____ Other: _____

Do you have a pacemaker? □ YES □ NO

Do you have an artificial joint? □ YES □ NO

Do you have an artificial heart valve? □ YES □ NO

Do you have to take antibiotics before you go to the dentist? □ YES □ NO Why? _____

Have you used tanning beds? □ YES □ NO

Please complete page 2

MEDICATIONS: Do you take prescription or over-the-counter medications regularly? Please List.

(1)_____ (4) _____

(2) _____ (5) _____

(3) _____ (6) _____

Are you allergic to any medications? □ YES □ NO If YES, *please list medication and your reaction to it*:

_____

Do you take blood thinners? □ YES □ NO If YES, *please list*: _____

_____

Have you taken aspirin in the last 48 hours? □ YES □ NO

Pharmacy Name and Telephone Number: _____

FAMILY HISTORY: Are there any diseases that run in your family? □ YES □ NO (*Please list*):

_____

Do you or any of your blood relatives have melanoma?	□ YES	□ NO	(relationship)	
Do you or any of your blood relatives have non- melanoma skin cancer?	□ YES	□ NO	(relationship)	
Do you or any of your blood relatives have psoriasis?	□ YES	□ NO	(relationship)	
Do you or any of your blood relatives have eczema?	□ YES	□ NO	(relationship)	

SOCIAL HISTORY: Do you smoke? □ YES □ NO

Do you drink alcohol beverages on a regular basis? □ YES □ NO

Occupation: What kind of work do you do? _____

REVIEW OF SYSTEMS: Do you have any current or past problems with any of the following?

			If YES, please describe:
General Health	□ YES	□ NO	
Eyes	□ YES	□ NO	
Ears/ Nose/ Throat/ Mouth	□ YES	□ NO	
Heart	□ YES	□ NO	
Liver	□ YES	□ NO	
Lungs	□ YES	□ NO	
Stomach/ Bowel	□ YES	□ NO	
Kidneys	□ YES	□ NO	
Headaches/ Seizures	□ YES	□ NO	
Psychological Disorder	□ YES	□ NO	
Thyroid/ Diabetes	□ YES	□ NO	
Blood/ Bleeding Disorder	□ YES	□ NO	
Females: Are you pregnant?	□ YES	□ NO	
Planning to become pregnant?	□ YES	□ NO	

I authorize Dr. Clark to release medical information to referring physicians.

_____ _____

Patient's Signature Today's Date Jason Clark, MD Today's Date