# Bayview North Dermatology Clinic

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**(Print) First and Last Name**____________________________ Email Address:________________________
Date of Birth: ______________Address:_______________________________________City:_____________
Postal Code:___________ Phone (Home):____________________ *****Cell Phone:**_____________________

**Emergency contact name (please print) and number:** _______________________________________________

Referring Doctor: ____________________ Family Doctor: ________________________

**Tell us your choice of reminder: Voice message:**☐ **<u>OR</u>** **Text message to your cell:** ☐ **<u>OR</u>** **E-mail:**☐

Have you seen this doctor before? ☐ No ☐ Yes When? ________________

**PRESENT PROBLEM(S):** what is the purpose of your visit today?______________________________
If you have a "rash on skin, or your skin has broken out" please complete the following:
indicate location:__________________________________________________________________________
Treatment(s) to date:_______________________________________________________________________
How long have you had the condition? _________________________________________________________
Other associated symptoms:__________________________________________________________________
Does your skin tend to be ☐ dry ☐ oily?
When you are exposed to the sun do you ☐tan ☐burn ☐burn and tan
Have you ever had a blistering sunburn before in your youth? ☐ No ☐ Yes

Do you have any **allergies to medications**? ☐ No ☐ Yes (please specify):

_____________________________________________________________________________________

Do you have to take antibiotics before you go to the dentist? ☐ No ☐ Yes (if yes why?)

_____________________________________________________________________________________

**MEDICATIONS**: Do you take any prescriptions, over-the-counter or herbal medications. List all:
1.________________________________ 5.________________________________
2.________________________________ 6.________________________________
3.________________________________ 7.________________________________
4.________________________________ 8.________________________________

Do you have a pacemaker? ☐ No ☐ Yes
Do you have an artificial joint? ☐No ☐Yes
Do you have an artificial heart valve? ☐ No ☐ Yes

Do you take blood thinners? ☐No ☐Yes (please list) __________________________________________

Have you taken aspirin in the last 48 hours? ☐No ☐Yes

Over →

**PAST MEDICAL HISTORY do you have any medical problems?**

| | **AUTO IMMUNE DISEASE LIKE**: |
|---|---|
| ☐ ASTHMA | ☐ LUPUS |
| ☐ HAY FEVER | ☐ RHEUMATOID ARTHRITIS |
| ☐ CANCER (SPECIFIC TYPE) | ☐ MS |
| ☐ DIABETES | ☐ THYROID |
| ☐ LIVER DISEASE | ☐ CROHN'S DISEASE |
| ☐ HIGH BLOOD PRESSURE | ☐ ULCERATIVE COLITIS |
| ☐ KIDNEY | ☐ ARTHRITIS |
| ☐ ECZEMA AS A CHILD | **OTHER CONCERNS**:________________________ |
| ☐ PSORIASIS | |
| ☐ HIGH CHOLESTROL | |

**Family History:** Are there any diseases that run in your family? ☐No ☐Yes (Please list family history of diseases)

________________________________________________________________________________

**Do you or any of your blood relatives have any of the following?**

SKIN CANCER ☐ No ☐Yes (Please indicate relationship) ________________________________________
MELANOMA ☐ No ☐ Yes (Please indicate relationship)________________________________________
PSORIASIS ☐ No ☐ Yes (Please indicate relationship)________________________________________
ECZEMA ☐ No ☐ Yes (Please indicate relationship)________________________________________
ASTHMA ☐ No ☐ Yes (Please indicate relationship)________________________________________
SCARRING ACNE ☐ No ☐ Yes (Please indicate relationship)____________________________________
PANCREATIC CANCER ☐No ☐ Yes (Please indicate relationship)___________________________________
AUTOIMMUNE DISEASE(Lupus or MS ETC.) ☐ No ☐Yes (Please indicate relationship)____________________

**Occupation (what kind of work do you do?):**________________________________________________

**Social History**: Do you smoke? ☐No ☐Yes
Do you use sunscreens? ☐No ☐Yes
Do you drink alcoholic beverages on regular basis? ☐No ☐Yes

**Females:** Are you pregnant or planning to become pregnant? ☐ No ☐ Yes ☐ Not Applicable

**Email:**
I agree to the usage of email to communicate with me or other responsible parties at the above email address if applicable.
I understand and authorize that private information may be contained in the email. ☐ **No** ☐ **Yes**

**Please confirm if you would like to receive our promotions for Botox/Fillers, skin care products or laser treatments via e-mail.** ☐ **No** ☐ **Yes**

I authorize the above named doctors; the ability to contact me with the information provided and releases my medical information concerning my visit to the referring physicians.

Is there anything else the doctor should know about regarding your health? ______________________________

____________________________________
*Patient Signature* *Date*