Patient Information & Medical History

Name: _____ Health Card #: _____ Version Code: _____
Last First

Address: _____ D.O.B.: _____ / _____ / _____ Age: _____
Unit Street DD MMM YYYY

_____
City/Municipality Postal Code

Main Phone: _____
Work Phone: _____
Cell Phone: _____
E-mail Address: _____
Your Occupation: _____

Referred by: Dr. _____
Family Physician: Dr. _____

For which skin problem were you referred? □ acne, □ rash, □ growth, □ warts, or □ other (please describe)
_____

When did you first notice this problem? _____

Have you previously treated this problem with creams, pills, medications or soaps? Please list ANYTHING you have used:
_____

Which body soaps do you use? _____

Which laundry soap, fabric softener and bleach do you use? _____

Do you use a sunscreen and, if so, which SPF? _____

Have you ever had skin cancer? Please specify _____

List any other skin problems you have had in the past: _____

List **all allergies** to medications (i.e. penicillin, aspirin, anesthetics, etc.) or any other substances (jewelry, poison ivy, etc.):
_____

Do you now or have you ever had (please check if yes)? □ stomach ulcers □ HIV □ blistering sunburn

□ Eczema □ hives □ easy bleeding □ Raynaud's disease □ allergy to cold temperatures

□ Asthma □ hepatitis □ tuberculosis □ rheumatic fever □ glaucoma □ diabetes

□ Seizures □ fainting □ high blood pressure □ pacemaker □ artificial joint □ artificial heart valve

Are you under the care of another doctor for any other condition? If yes, for which conditions? _____

Please list any **pills, vitamins or creams** (including aspirin and birth control) that you are currently taking/using: _____
_____
_____

Have any family members had (please check if yes and specify which family member(s))?
□ Melanoma _____ □ eczema _____ □ psoriasis _____

I give my permission for Dr. Guenther and her assistants to leave messages on my answering service. □ Yes □ No

I give my permission for Dr. Guenther and her assistants to review my chart for purposes of clinical research and I give my permission for them to contact me if I might benefit from potential new treatment(s). □ Yes □ No

If you are a woman, are you pregnant or trying to get pregnant? □ Yes □ No Are you breast-feeding? □ Yes □ No

Patient or Guardian signature: _____ Date signed: _____

PLEASE GIVE 24 HOUR CANCELLATION NOTICE
Due to a shortage of dermatologists, heavy patient demands and surgical procedures, a wait may be experienced. We appreciate your patience.