NEWTON-WELLESLEY DERMATOLOGY ASSOCIATES
Patient Medical Information Sheet

Name:_____ **DOB**:_____ **Date:**_____

Who referred you to our office: _____
Occupation: _____

Reason for visit	**Location of Problem**	**Duration of Problem**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical History/Review of Systems:	**Yes**	**No**	**Details**
Currently Pregnant:	__	___	_____
Bleeding disorder:	__	___	_____
History of a blood clot or stroke:	__	___	_____
Diabetes:	__	___	_____
Cancer of any kind:	__	___	_____
Heart disease (or MVP):	__	___	_____
High blood pressure:	__	___	_____
Eye problems:	__	__	_____
Asthma or lung disease:	__	___	_____
Ear, nose or throat problem:	__	___	_____
Breast problem:	__	___	_____
Thyroid problem:	__	___	_____
Gastrointestinal disorder or ulcer:	__	___	_____
Genital or gynecological problem:	__	___	_____
Bone or joint disease:	__	___	_____
Infectious disease:	__	___	_____
Neurologic or seizure disorder:	__	___	_____
Psychiatric problem or depression:	__	___	_____

Medications:
None ____
_____
_____
_____
_____
_____

Allergies to Medications:
None __
_____
_____
_____
_____
_____

Other Allergies:
_____
_____

Prior surgical procedures: _____ Other problems not listed:_____

Have you or a family member ever had the following?			
Problem	Self	Family	(which member)
Psoriasis	__	___	_____
Eczema	__	__	_____
Asthma/Allergies	__	___	_____
Skin Cancer	__	___	_____

(Circle skin cancer if known) Basal Cell, Squamous Cell, Melanoma

Social History	**Yes**	**No**
Do you smoke?	__	___
Drink alcohol?	__	___
Live alone?	__	___
Live with family/spouse?	__	___
Do you use sunscreen?	__	___

Children: number____ ages_____

Signed: _____ **Date**:_____
(Patient or Guardian)
Reviewed by: _____ **M.D. / P.A**

Please check the box if you wish to receive information about any of the following:

Laser Treatment Brown Spots____ Vessels____ Skin Care Products____ Botox ____ Juvederm_____ Chemical Peels_____