DERMATOLOGY ASSOCIATES
NEW PATIENT INFORMATION (PEDIATRICS)

Patient Name: ______________________________

Date of Birth: ______________________________

Intake Form (Pediatric)

Age: ____________________

Weight: ____________________

Referred by: (first and last name)

____

Primary Medical Physician:

____________________________________ In which city/state? ______________________________

Guardian(s) Name:____________________________________ Relationship: ____________________
Last Name First Name

Guardian(s) Name:____________________________________ Relationship: ____________________
Last Name First Name
With whom does the patient live? (Circle above)

Please describe the reason for this visit to the dermatologist: ______________________________

____

Personal / Family Medical History

Have you experienced:	**In yourself?**		**In your family? (specify who)**
Skin Cancer (if yes please specify type): ____________	N	Y	____________
Other Cancer (if yes please specify type): ____________	N	Y	____________
Eczema / Psoriasis (circle one)	N	Y	____________
Seasonal allergies, asthma, migraines (circle one)	N	Y	____________
Difficulties with scarring or keloids	N	Y	____________
Difficulties with skin infections or infected wounds	N	Y	____________

Female patients: please inform your doctor if you are pregnant, or plan on becoming pregnant during your treatment period.
N Y ____________

Please list all other conditions for which you are currently receiving treatment

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2008/09

For office use only:

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Patient Name: ____________________

Date of Birth: ____________________

Past surgical history / hospitalizations and dates:

____

____

____

Please list all medications you are currently taking:

Allergies / Adverse Reactions

1. Food allergies: ____________________

____

2. Medication allergies (please list reaction, if known): ____________________

____

Social History

Name of school: ____________________

If the patient is in school, does he or she have difficulties at school? □ No □ Yes, explanation:

____

Pets at home: ____________________

Hobbies / after school activities: ____________________

Contact Information

If we need to get in touch with you regarding test results M-F, 8-5, what is the best way to reach you? (Please circle one.) HOME CELL WORK EMAIL

Please enter the contact number/email here: ____________________

If you are not at home, do we have permission to leave a message with personal information? □ N □ Y

Name of contact person: ____________________

Pharmacy: (name) ____________________ (location) ____________________

Phone number (if known): (________) __________ - ____________________

Patients: Please fill in date this form was completed: __________ / __________ / __________
Month Day Year

OFFICE USE ONLY: Reviewed, and all pertinent positives discussed with patient.