



One Hospital Drive
Columbia, MO 65212
573/882-4141

Patient Name: _____

Medical Record No: _____

Dermatology Clinic Patient Information Sheet

Patient Information

Name _____ Date _____

Please circle any symptoms, sign, or conditions you are currently experiencing:

Fever Nausea/vomiting Mole changes Itching Skin rashes
Pregnancy Diarrhea New growth Non-healing sores
Tenderness None of the above _____

Past Medical History/Family History

<u>Disease</u>	<u>Yourself</u>	<u>Family</u>	<u>Disease</u>	<u>Yourself</u>	<u>Family</u>
Acne	_____	_____	High cholesterol	_____	_____
Asthma/hayfever	_____	_____	Kidney disease	_____	_____
Bleeding disorder	_____	_____	Joint replacement	_____	_____
Depression	_____	_____	Liver dz/hepatitis	_____	_____
Diabetes	_____	_____	Psoriasis	_____	_____
Eczema	_____	_____	Recurrent yeast inf.	_____	_____
Fever blister	_____	_____	Skin cancer	_____	_____
Heart or renal	_____	_____	Melanoma	_____	_____
transplant	_____	_____	Thyroid disease	_____	_____
Heart valve dz/ Murmur	_____	_____			

What is your occupation? _____ Do you smoke? Yes__ No__

What outdoor activities do you enjoy? _____

Do you drink alcohol? Yes__ No__ How often? _____

Do you wear sunscreen? Yes__ No__ Have you ever used a tanning bed? Yes__ No__

Have you ever had a blistering sunburn? Yes__ No__ Are you a student/ Yes__ NO__

Are you planning a pregnancy? Yes__ No__ Date of last menstrual period _____

Current medications including non-prescription meds and birth control pills

Medication allergies _____

Daytime phone _____ Evening/cell phone _____ Preferred pharmacy _____

Patient Signature _____ Date _____