Wasserman Ulitsky DERMATOLOGY

New Patient Information Sheet

Patient Name (Print): _____ Age: _____

DOB: ____/_____/_____ Social Security Number: _____-_____-_____ Sex: M / F

Address: _____

Height:_____ Weight: _____ Race: _____ Ethnicity:_____ Language:_____

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?

Home:_____ Cell:_____ Work:_____

Email:_____@_____

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

Please List here the names of people that have permission to receive information or results:

_____

Referred by:_____ Primary Medical Physician:_____

Medical Insurance/Medicare policy Number: _____

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

_____

Pharmacy Information:

Local Pharmacy Name:_____ Local Pharmacy phone #:_____

Mail Order Pharmacy Name:_____ Mail Order Pharmacy phone #:_____

Do you prefer a 90 day supply if applicable? ☐Yes ☐No

Allergies/Adverse Reactions: (Please list reaction if known)

Medication Allergies:_____

_____

Food Allergies:_____

_____

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, hay fever (circle)	N	Y	_____
Difficulties with bleeding or clotting (circle)	N	Y	_____
Difficulties with scarring or keloids:	N	Y	_____
Do you have or suspect you have HIV/AIDS/Hepatitis C?	N	Y	_____

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Female Patients: please inform your doctor if you are pregnant, or plan on becoming pregnant during your treatment period. N Y Last Menstrual Period: _____/_____/_____

Please List all other conditions for which you are currently receiving treatment:_____
_____

Past Surgical History /Hospitalizations and approximate dates: _____
_____

Please list all medications you are currently taking or provide list:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Social History:

Marital Status: ☐Single ☐Married ☐Divorced ☐Domestic Partner ☐Separated ☐Widowed

Occupation:_____ Retired? N Y

Tobacco use: N Y Type:_____ Amount:_____ How Often_____

Alcohol use: N Y Type:_____ Amount:_____ How Often_____

Have you ever used a sun tanning booth? N Y If yes, how often? _____
Do you use sunscreen regularly? N Y If yes, what SPF? _____

I hereby swear that the above information is true and accurate to the best of my knowledge.

Patient Signature:_____ Date: _____/_____/_____