



Patient: _____ Date: _____ D.O.B.: _____ Gender: F M

Referring provider: _____

Ethnicity: White Hispanic Black/African-American Asian Native American Other: _____

List all medications you are currently taking (including prescription, over-the-counter, vitamins, herbals, and topicals):

Do you have any allergies to medications? No Yes, list type of reaction: _____

Do you use tobacco products? No Yes, type: _____ How long? _____

Reason for today's visit: _____

Current area(s) affected: Scalp Face Eyelids Top of hand Palm Fingertips Between fingers Arms Chest Back Genitals
 Legs Feet

Symptoms: Itching Pain Peeling Burning Cracking Redness

When did you first notice this problem? _____ Continuous Intermittent

List current medical conditions: _____

History of biopsies Explain: _____

History of allergic conditions and skin disease: Asthma Hay fever Eczema Hives Psoriasis Other: _____

Family history of skin disease: Eczema Psoriasis Other: _____

Healthcare & personal devices: Implants _____ Crowns/bridges _____
 Braces _____ Gold Other: _____
 Tattoos _____ Fillings _____
 Stents _____ Amalgam Other: _____
 Piercings _____ Other: _____

Personal information:

Occupation: _____

Job description: _____

Employer: _____ Since (date): _____

Do symptoms improve during weekends/holidays/vacations: No Yes Loss of work: No Yes, on dates: _____

Signature: Completed by: Patient Parent/guardian Nurse: _____

Patient signature: _____ Date: _____

Reviewed by: _____ Date: _____