Patient Name: ________________________________
Date of Birth: ____/____/_______
Today's Date: ____/____/_______
Appointment Time: ____________

New Patient Pediatric Form

Name: ____
(Please Print First, M, Last)

Date of Birth: ________________________
Sex: ☐ Female ☐ Male **Marital Status:** ________________ **SSN:** ______________________

Home Address:____

Email: _____________________________________ Can we contact you at this email address? ☐Yes ☐No

Preferred Phone Number: _____________________**Alternate Phone Number:** ______________________

Responsible Party (if different from patient) Name: ____
Relationship to patient: _______________ Phone:___ ________________
Address: ____

Emergency Contact: Name: ____________________________ Phone: ______________________________
Relationship to patient: ______________________________

How did you hear about us? (Please check all that applies) ☐Friends or Family? Their name ___________________
☐Your Insurance ☐Your Physician ☐Our Website ☐Other Website ☐Yelp ☐Social Media

Preferred Language: ________________________
Race: ☐White ☐Black/African American ☐American Indian or Native Alaskan
☐Asian ☐Native Hawaiian/Pacific Islander ☐ People of Two or More Races
Ethnicity: ☐Hispanic/Latino ☐Non-Hispanic/Latino ☐ Unspecified

Pharmacy: Name:____
Address or cross street: ____

Primary Care Physician: ____
phone: ___________________ Fax: ________________________

Referring Physician: ____
phone: ___________________ Fax: _________________________

Patient Name: ________________________________
Date of Birth: ____/____/_______
Today's Date: ____/____/_______
Appointment Time: ____________

Past Medical History: (please mark & circle all that apply)

- ☐ Arthritis, Lupus, Autoimmune Disease
- ☐ Hepatitis B, Hepatitis C, HIV/AIDS
- ☐ Blood transfusion, Bone Marrow or Organ Transplant
- ☐ Anxiety, Depression, Eating Disorder, Psychological problems
- ☐ Asthma, Tuberculosis, COPD, Emphysema, Chest Disease
- ☐ Acid Reflux, (GERD), Stomach Ulcers
- ☐ Faint Spells, Seizures, Stroke, Neurological Disease
- ☐ High or Low Blood pressure, High Cholesterol
- ☐ Diabetes, Thyroid disease
- ☐ Liver Disease, Jaundice, Cirrhosis
- ☐ Artificial Joints
- ☐ Drug Abuse, Alcohol Abuse
- ☐ Hearing Loss
- ☐ Kidney Disease, Prostatic Disease
- ☐ Migraines, Headaches, Chronic Pain
- ☐ Anemia, Blood/Bleeding Disease
- ☐ Heart Disease, Pacemaker, Valve Replacement, Atrial Fibrillation, Coronary Artery Disease
- ☐ Breast Cancer, Lung Cancer, Colon Cancer, Prostate Cancer, Leukemia, Lymphoma
- ☐ Radiation Treatment
- ☐ Other ___________________________

Pediatric History:

Gestational age at birth (in weeks)? ________________________

Maternal or Neonatal complications?________________________

Meeting Developmental Milestones? ☐ Yes ☐ No

Has your child had any surgeries in the past? (Please indicate dates): ________________________________

____

Do your child have any history of skin disease?____

Do your child wear Sunscreen? ☐ Yes ☐ No Which Brand? ______________

Does your child tan in a tanning salon? ☐ Yes ☐ No

Does your child have a family history of Melanoma? ☐ Yes ☐ No Which Relative?_____________

Has your child ever had a full skin exam? ____

Medications: (Please enter all current medications): ____

Allergies: (Please enter all allergies and the type of reaction you had): ___________________________________

____

Social History:

- ☐ Who does the child live with? ____
- ☐ Other caregivers? ____
- ☐ Siblings/Their ages?____
- ☐ Does your child smoke?____
- ☐ Is you child sexually acctive?____

Patient Name: ________________________________
Date of Birth: ____/____/_______
Today's Date: ____/____/_______
Appointment Time: ____________

Main reason for today's visit:____

Location? ____

Qualities of your condition? ☐Red ☐Darkening ☐Itching ☐Flaking ☐Pain/tenderness ☐Burning/Blistering ☐Enlarging ☐Changing ☐Spreading ☐No symptoms ☐Other:_________

How would you describe severity of your condition? ☐Mild ☐Moderates ☐Severe

Duration of your condition? ____days ____ months ____years

Anything that makes your condition better or worse (modifying factors)**?**________________________________

Have you used any prescription medication for your condition?____________________________________

Have you used any non-prescription treatments for your condition?________________________________

Is there another skin condition or treatment you would like to discuss? ____________________________

TODAY, are you experiencing any of the following symptoms? (Review of Systems)

☐ Problems with healing or scarring (hypertrophic or keloid) ☐ Problems with bleeding
☐ Fevers or Chills ☐ Unintentional Weight loss ☐ Immunosuppression
☐ Joint Aches/Muscle Weakness ☐ Headaches ☐ Shortness of Breath
☐ Chest Pain ☐ Abdominal Pain ☐ None

! SAFETY ! To help us provide safe treatments, please mark all that apply to you today:

- Pregnancy or planning a pregnancy ☐Yes ☐No
- History of MRSA/resistant staphylococcus infection ☐Yes ☐No
- History of or exposure to HIV infection ☐Yes ☐No
- History of or exposure to Hepatitis B or Hepatitis C ☐Yes ☐No

- Allergy to any of the following? ☐Latex ☐Adhesives ☐Lidocaine ☐Topical Antibiotics ☐Bees ☐No
- Do you get rapid heartbeat with numbing injections (epinephrine) ☐Yes ☐No
- Do you have a Defibrillator, Pacemaker, Artificial heart valve, or Artificial joints placement? ☐Yes ☐No
- Are you required to take antibiotic premedication prior to surgical procedures? ☐Yes ☐No
- Are you on any blood thinners? ____ ☐Yes ☐No
- Have you taken any of the following in the last 2 weeks?
  - ☐Anti-inflammatories or muscle relaxants such as Ibuprofen/Motrin/Advil/Nuprin
  - ☐Aspirin (or aspirin containing medications) ☐Vitamin E ☐ Omega 3
  - ☐ Ginkgo Biloba, Garlic, Ginseng, Ginger, Dong quai, Ephedra, Feverfew. St. John's wort ☐No