

# SHORELINE DERMATOLOGY

5 Durham Rd, Guilford, CT 06437

203-453-8625

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
Reason for today's visit \_\_\_\_\_ Date of birth: \_\_\_\_\_ (age: \_\_\_\_\_)

**How did you hear about us?** Physician, Dr. \_\_\_\_\_ Friend/family \_\_\_\_\_  
Yellow Pages \_\_\_\_\_ TV \_\_\_\_\_ Internet \_\_\_\_\_ Newspaper \_\_\_\_\_

## Medications

Please list all prescription medication (with dosage) that you are taking. Also include any herbal supplements, vitamins or non-prescription medications:

Do you take aspirin? Yes/No

Are you allergic to any medications? Yes/No If yes, list: \_\_\_\_\_

## Medical History

	<u>Yes</u>	<u>No</u>	<u>If yes, please explain:</u>
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears/Nose/Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stomach/bowel	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidneys	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis/muscle/joints	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin disease (ie eczema, acne, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Headaches/seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fainting/Lightheadedness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid/diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood/bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Liver/Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

## Family History

Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hayfever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	_____

## Social History

Do you smoke? Yes/No

Do you drink alcohol? Yes/No

Females: Are you pregnant? Yes/No

## Surgical History

Please list all surgeries or operations (including cosmetic) that you have had:

<u>Procedure</u>	<u>Date</u>
_____	_____
_____	_____
_____	_____
_____	_____