A Children's House for Pediatric Dermatology
NEW PATIENT QUESTIONNAIRE

Patient Name: ____Nickname: ________________________
Last First Middle

Address: ____ Home phone: ______________________
City Zip

Date of Birth: ___________________ SSN: ________________ Current Age: _________ Male/Female: ___________

School: ___________________________ Current grade: _______ Hobbies/Sports: ______________________________

Mother's Name: ____ Cell: ______________________________

Mother's Occupation: __________________________________ Mother's Email: __________________________________

Father's Name: ____ Cell: ______________________________

Father's Occupation: ___________________________________ Father's Email: ___________________________________

Siblings (names and ages): ____

Patient lives with: ____

Religious/spiritual /faith affiliation, if any: _______________________________ May we pray with you?: Yes or No

How did you hear about us? ____

Current Pediatrician (name and info): ____

Current Subspecialists: ____

Preferred Pharmacy (address and phone): ____

Current problems (include onset, timing, location, associated symptoms, previous treatments with response):

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Current skin care regimen (soaps, moisturizers, over-the counter medications, etc), if any:

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Birth history (weight, length, full-term, complications): ______________________________

Health Conditions: ______________________________

Developmental or learning issues: ______________________________

Previous surgeries or hospitalizations: ______________________________

Medications, include vitamins, etc: ______________________________

Allergies to medication, food, etc: ______________________________

Review of systems	**Yes**	**No**	**Family history**	**Yes**	**No**	**Relationship**
Weight loss or gain			Skin cancer			
Recent fever			Melanoma			
Vision changes			Eczema			
Ear/nose/throat issues			Asthma			
Swollen glands			Hay fever			
Recurrent infections			Autoimmune disorders			
Breathing problems			Bleeding problems			
Heart problems			Anesthesia problems			
Bleeding problems			**Social history**	**Yes**	**No**	**Explanation**
Vomiting/diarrhea			Vaccines up to date			
Muscle aches/weakness			Pets			
Swollen joints			Alcohol use			
Kidney/bladder issues			Tobacco use			
Irregular periods			Illicit drug use			
Headaches			Sexually active			
Depression/anxiety						
Difficulty sleeping						

Person completing form and relationship to patient: ______________________________

Physician signature and date reviewed: ______________________________