A Children's House for Pediatric Dermatology
NEW PATIENT QUESTIONNAIRE

Patient Name: _____ Nickname: _____
First Middle Last

Address: _____ Home phone: _____
City Zip

Date of Birth: _____ Age: _____ Gender Identity: _____

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):

_____

_____

_____

_____

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

_____

_____

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**
Abnormal weight change			Skin cancer			
Recent fever			Melanoma			
Vision changes			Eczema			
Ear/nose/throat issues			Asthma			
Swollen glands			Environmental allergies			
Recurrent infections			Autoimmune disorders			
Breathing problems			Bleeding problems			
Heart problems			Anesthesia problems			
Bleeding problems			Scarring acne			
Vomiting/diarrhea			**Social history**	**Yes**	**No**	**Explanation**
Constipation			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: _____