

Patient Information

Last Name _____ First _____ Middle Initial _____
 Date of Birth ___/___/___ Sex: M F Preferred Contact Phone # _____
 Address _____
 City _____ State _____ Zip _____

Primary Care Physician _____ PCP Phone # _____
 Preferred Pharmacy _____ Location _____ Phone# _____
 Emergency Contact Name/Relationship _____ Phone# _____
 Referring Physician (if any) _____

Medical History

Have you been diagnosed with or had any of the following conditions/treatments?

- | | | | |
|---------------------|--|-----------------------------|--|
| Diabetes mellitus | <input type="checkbox"/> yes <input type="checkbox"/> no | Depression | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Heart disease | <input type="checkbox"/> yes <input type="checkbox"/> no | Anxiety | <input type="checkbox"/> yes <input type="checkbox"/> no |
| High blood pressure | <input type="checkbox"/> yes <input type="checkbox"/> no | Pacemaker/defibrillator | <input type="checkbox"/> yes <input type="checkbox"/> no |
| High cholesterol | <input type="checkbox"/> yes <input type="checkbox"/> no | Artificial joints | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Arrhythmia | <input type="checkbox"/> yes <input type="checkbox"/> no | Pre-dental work antibiotics | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Fainting/syncope | <input type="checkbox"/> yes <input type="checkbox"/> no | Artificial heart valves | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Asthma | <input type="checkbox"/> yes <input type="checkbox"/> no | Arthritis | <input type="checkbox"/> yes <input type="checkbox"/> no |
| COPD | <input type="checkbox"/> yes <input type="checkbox"/> no | Bleeding disorder | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Thyroid disease | <input type="checkbox"/> yes <input type="checkbox"/> no | Clotting disorder | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Kidney disease | <input type="checkbox"/> yes <input type="checkbox"/> no | Anticoagulant treatment | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Memory problems | <input type="checkbox"/> yes <input type="checkbox"/> no | Cancer | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Crohn's disease | <input type="checkbox"/> yes <input type="checkbox"/> no | Lymphoma | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Ulcerative colitis | <input type="checkbox"/> yes <input type="checkbox"/> no | Leukemia | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Lupus | <input type="checkbox"/> yes <input type="checkbox"/> no | Organ transplant | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Psoriasis | <input type="checkbox"/> yes <input type="checkbox"/> no | MRSA | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Eczema | <input type="checkbox"/> yes <input type="checkbox"/> no | Immunosuppression | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Hay fever | <input type="checkbox"/> yes <input type="checkbox"/> no | HIV Positive | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Cold sore/HSV | <input type="checkbox"/> yes <input type="checkbox"/> no | Hepatitis | <input type="checkbox"/> yes <input type="checkbox"/> no |
| | | Other: | _____ |

Women's only history:

Are you pregnant? yes no
 If yes, how many weeks pregnant are you? _____
 Are you currently nursing? yes no
 Are you currently using any form of pregnancy contraception? yes no
 If yes, please list the form (oral, intra-uterine, implantable, etc): _____

Skin Cancer History

Do you have a personal history of melanoma? yes no
 Do you have a family history of melanoma? yes no
 If yes, please note the relationship of this relative: _____
 Do you have a personal history of non-melanoma skin cancer (for example, basal cell carcinoma, squamous cell carcinoma etc., other skin cancer)? yes no
 If yes, please list the skin cancer type: _____

Vaccinations

Are your immunizations up to date? yes no
 Have you received the influenza vaccine? yes no
 Have you received the shingles/herpes zoster vaccine? yes no
 Have you received the Covid vaccine? yes no

Allergies

Do you have any known medication, adhesive or other allergy? yes no
If the answer is No, you may skip to the section titled Current Medications.
 Do you have an allergy to lidocaine? yes no
 Do you have an allergy to epinephrine? yes no
 Do you have an allergy to latex? yes no
 Do you have an allergy to adhesive tape? yes no
 Please list any known allergies below:

Current Medications

- | | |
|----------|-----------|
| 1. _____ | 8. _____ |
| 2. _____ | 9. _____ |
| 3. _____ | 10. _____ |
| 4. _____ | 11. _____ |
| 5. _____ | 12. _____ |
| 6. _____ | 13. _____ |
| 7. _____ | 14. _____ |

Do you take any supplements (ie. prenatal, vitamin D, St. John's wort)? yes no
 If yes, please list below:

Past Surgical History

Type of surgery <i>(Include Left or Right side when appropriate)</i>	Year
_____	_____
_____	_____
_____	_____

Social History

Do you use tobacco? yes no
 Do you smoke cigarettes? yes no
 If yes, for how many years have you smoked? _____
 If yes, please list the number of packs you smoke per day: _____
 Do you engage in recreational drug use? yes no
 Do you drink alcohol? yes no
 If yes, how many alcoholic beverages do you consume per week? _____
 Have you had exposure to tanning beds? yes no
 Have you had blistering sun burns in the past? yes no
 Do you use sunscreen regularly? yes no

Reason for today's visit: _____

Are you having any of the following symptoms?

Fever <input type="checkbox"/> yes <input type="checkbox"/> no	Joint pain <input type="checkbox"/> yes <input type="checkbox"/> no
Chills <input type="checkbox"/> yes <input type="checkbox"/> no	Muscle aches <input type="checkbox"/> yes <input type="checkbox"/> no
Fatigue <input type="checkbox"/> yes <input type="checkbox"/> no	Headache <input type="checkbox"/> yes <input type="checkbox"/> no
Weight loss <input type="checkbox"/> yes <input type="checkbox"/> no	Easy bruising <input type="checkbox"/> yes <input type="checkbox"/> no
Chest pain <input type="checkbox"/> yes <input type="checkbox"/> no	Rash/itch <input type="checkbox"/> yes <input type="checkbox"/> no
Abdominal pain <input type="checkbox"/> yes <input type="checkbox"/> no	Swollen lymph nodes <input type="checkbox"/> yes <input type="checkbox"/> no
Nausea <input type="checkbox"/> yes <input type="checkbox"/> no	Eye pain or discomfort <input type="checkbox"/> yes <input type="checkbox"/> no
Vomiting <input type="checkbox"/> yes <input type="checkbox"/> no	
Diarrhea <input type="checkbox"/> yes <input type="checkbox"/> no	
Cough <input type="checkbox"/> yes <input type="checkbox"/> no	
Shortness of breath or difficulty breathing <input type="checkbox"/> yes <input type="checkbox"/> no	



Appointment No-Show, Change & Cancellation Policy

Nahhas Dermatology at the Toledo Clinic strives to provide the highest level of patient care and respects patient's time in our office. Our office will require **24-hour** notice to change or cancel an appointment. Patients arriving more than 20 minutes after the appointment start time may have to reschedule. The **no-show fee is \$50 for medical appointments, \$200 for surgical appointments, and \$75 for cosmetic appointments.** This policy allows our office to function with efficiency and provide the best care to all of our patients.

Please sign date and time to communicate acceptance of this policy.

Signature here _____ Date _____ Time _____