

**Patient Information**

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

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 |
| Arrythmia           | <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 |
| Hearing Loss        | <input type="checkbox"/> yes <input type="checkbox"/> no | MS/ALS/neurologic disease   | <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): \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_

**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:

Name \_\_\_\_\_ DOB \_\_\_\_\_

**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 currently 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	

Name \_\_\_\_\_ DOB \_\_\_\_\_

We would also love to hear how you heard about the practice? This is important so we can learn the best ways to integrate into and serve our community!

- Referred by primary care physician
- Referred by family/friend: \_\_\_\_\_
- Social Media (Facebook, Toledo Clinic adds)
- Other: \_\_\_\_\_

**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 \$50 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 \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_