Pediatric Dermatology of Dallas, PA

NEW PATIENT HISTORY

SOURCES OF INFORMATION

Name of Child: _____
Name that child likes to be called: _____
Child's Age _____
Person Providing Information: _____
Relationship to Child: _____
Phone # where parent may be reached during the day: _____
_____
Language Spoken: _____

CHIEF COMPLAINT

Reason(s) for today's visit: _____
_____
_____
_____
_____

HISTORY OF PRESENT ILLNESS AND REVIEW OF SYSTEMS

Is your child having any of the following problems **TODAY**?:

Itching	No __ / Yes __ :	_____
Blisters	No __ / Yes __ :	_____
Fever	No __ / Yes __ :	_____
Hair Loss	No __ / Yes __ :	_____
Sores	No __ / Yes __ :	_____
Warts	No __ / Yes __ :	_____
Pain / Tenderness	No __ / Yes __ :	_____
Birthmarks	No __ / Yes __ :	_____
Eye / Ear Symptoms	No __ / Yes __ :	_____
Nose / Throat Symptoms	No __ / Yes __ :	_____
Weight Gain	No __ / Yes __ :	_____
Weight Loss	No __ / Yes __ :	_____
Headache	No __ / Yes __ :	_____
Fatigue	No __ / Yes __ :	_____
Nausea / Vomiting	No __ / Yes __ :	_____
Diarrhea	No __ / Yes __ :	_____
Abdominal Pain	No __ / Yes __ :	_____
Swollen Lymph Nodes	No __ / Yes __ :	_____
Change in Vision	No __ / Yes __ :	_____
Cough	No __ / Yes __ :	_____
Shortness of Breath	No __ / Yes __ :	_____
Pain / Difficulty Urinating	No __ / Yes __ :	_____
Depression	No __ / Yes __ :	_____

Is your child experiencing any other problems? _____
_____
_____
_____

PAST HISTORY

Are immunizations UP TO DATE? No __ / Yes __
Is your child allergic to any medications or to LATEX? No __ / Yes __
Please list: _____
_____
_____

PAST MEDICAL AND SOCAL HISTORY

Has your child ever been hospitalized or had any serious illnesses or injuries? No __ / Yes __
Please list: _____
Has your child ever had any operations? No __ / Yes __
Please list: _____

Does your child smoke? No __ / Yes __
Does your child drink alcohol? No __ / Yes __
Does your child have an artificial heart valve or require antibiotics before dental work or other procedures? No __ / Yes __

If your child is female: Is she menstruating yet? No __ / Yes __
Is there any chance that she could be pregnant? No __ / Yes __
Is she planning a pregnancy? No __ / Yes __

PATIENT MEDICAL HISTORY

Check the appropriate box if your child or other family members have had any of the following conditions:

CONDITION	Child	Family
Arthritis	☐	☐
Acne	☐	☐
Blood Disorders	☐	☐
Asthma	☐	☐
Cancer or Leukemia	☐	☐
Liver Disease	☐	☐
Diabetes	☐	☐
Eczema	☐	☐
Heart Disease	☐	☐
Hepatitis	☐	☐
High Blood Pressure	☐	☐
HIV / AIDS	☐	☐
Immune Suppression	☐	☐
Kidney Disease	☐	☐
Melanoma	☐	☐
Non-Melanoma Skin Cancer	☐	☐
Organ Transplant	☐	☐
Pneumonia	☐	☐
Psoriasis	☐	☐
Seasonal Allergies	☐	☐
Seizures	☐	☐
Psychiatric Problems or Depression	☐	☐
Stroke	☐	☐
Thyroid Disease	☐	☐

Do any other skin disorders run in the family? No __ / Yes __
Please list: _____
_____

MEDICATIONS

Is your child taking any medications: No __ / Yes __
Please list (include topical cremes or herbal medications): _____
_____
_____
_____
_____
_____
_____