Piedmont HealthCare
DERMATOLOGY

NEW PATIENT

Patient Name:
Chart #: **Date:** **Appt Time:**

Did another physician refer you? Who?

Allergies to Medicines:

Current Medications:

REASON FOR TODAY"S VISIT: (chief complaint) Please include duration, location, symptoms, prior treatments.

CURRENT OR PAST PROBLEMS WITH: (review of systems)

	Yes	No	(If yes, please explain)
General Health			
Arthritis/muscles/joints			
Skin			
Thyroid/Diabetes			
Blood/Bleeding disorder			
Local anesthetic reaction			
Artificial joint or heart valve/pacemaker			
Other (please list):			

FEMALES: Are you pregnant? planning to become pregnant? Breast Feeding?

CIRCLE: the following medical conditions that have occurred in you or a family member and list who had them:

Allergies:
Arthritis:
Asthma:
Eczema:
Melanoma/Skin Cancer:
Psoriasis

Social History:
Do you smoke? Do you drink alcohol? What is your occupation?

----------**Do not write below this line**----------

_____ _____
Steven F. Wolfe, M.D. Today's date