

# PARKS DERMATOLOGY CENTER

400 Lakebridge Plaza Drive • Ormond Beach, Florida 32174  
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## Patient Information Form

Date \_\_\_\_\_

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Occupation \_\_\_\_\_

SS# \_\_\_\_\_

What are you seeing the doctor for today? \_\_\_\_\_

When did the problem begin? \_\_\_\_\_

What have you tried in the past? \_\_\_\_\_ Did it help?  Yes  No

List any allergies to medicines:  None 1. \_\_\_\_\_ Reaction \_\_\_\_\_

List allergies to: rubber, latex, nickel, foods, flowers, plants, weeds, etc. \_\_\_\_\_

Medications you take or apply (including eye drops)  None

1. \_\_\_\_\_

3. \_\_\_\_\_

2. \_\_\_\_\_

4. \_\_\_\_\_

YES NO

- Aspirin  
  OTC Products (such as: vitamins, Tylenol, laxatives, etc.)  
  Anti-inflammatory (eg. Advil, Motrin)  
  Do you use tobacco? If yes,  
how much, \_\_\_\_\_ packs per day  
  Do you drink alcohol? If yes, how much  
\_\_\_\_\_ drinks per day/week/month

YES NO

- Do you use recreational drugs? If yes,  
which drugs? \_\_\_\_\_  
  Have you ever had skin cancer? If yes,  
type \_\_\_\_\_  
  Has anyone in your family ever had skin cancer?  
  Have you ever had melanoma?  
  Has anyone in your family had melanoma?

Do YOU have or have you ever been diagnosed with any of the following medical conditions?

YES NO

- High Blood Pressure  
  Heart Disease  
  Angina, Heart Attack  
  Murmur  
  Mitral valve prolapse  
  Pacemaker  
  Artificial Valves  
  Faint Easily  
  Stroke, paralysis  
  Blood clots  
  Bleeding Gums

YES NO

- Anemia  
  Lung Disease  
  Asthma  
  Hay fever, sinus/allergy  
  Tuberculosis  
  HIV  
  Gastrointestinal Disorder  
  Ulcers  
  Hepatitis/Jaundice  
  Liver problems  
  Kidney disease

YES NO

- Diabetes (sugar)  
  Thyroid problems  
  Irregular periods  
  Excess hair growth  
  Keloids/Abnormal Scarring  
  Cataracts or Glaucoma  
  Cancer, type \_\_\_\_\_  
  Artificial joints  
  Joint pain, which joints \_\_\_\_\_  
  Trouble urinating  
  Nervous/Mental problems

Who is your primary physician \_\_\_\_\_

### FEMALES

Name of pharmacy \_\_\_\_\_

Do you have a prescription  
plan through your ins. \_\_\_\_\_

- Are you taking birth controls?  
  Are you pregnant now or considering pregnancy?  
  Are you breast feeding?

List any allergies  None \_\_\_\_\_

Did a doctor refer you to our clinic? If yes, their name \_\_\_\_\_

Is there anything else the doctor should know? \_\_\_\_\_

Do we have your permission to:

Leave a message on your answering machine at home?  Y  N

Leave a message at your place of employment?  Y  N

Discuss your medical condition with any member of your household?  Y  N

If yes, whom: \_\_\_\_\_ Relationship \_\_\_\_\_

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_