Hartford Dermatology Associates, P.C. • Pediatric Dermatology of New England

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Intake Questionnaire

Name _____ **DOB** _____ **Sex** _____

What brings you to see us? _____

Who referred you to our office? _____

Medical History:

If patient is less than 5 years old, list birth weight _____ Was baby premature? _____ Pregnancy Duration _____ weeks

Multiple birth or pregnancy complications? _____

Have you ever been diagnosed with **skin cancer** or other **skin problems**? (Examples: psoriasis, eczema, abnormal moles)

☐ No ☐ Yes – please list: _____

Do you have any of the following **medical conditions**? If yes, please list or describe.

Hayfever/Seasonal allergies/asthma	☐ no	☐ yes _____
Genetic condition or syndrome	☐ no	☐ yes _____
Thyroid disease	☐ no	☐ yes _____
Cancer	☐ no	☐ yes _____
Emotional/Neurological disease/autism	☐ no	☐ yes _____
Diabetes	☐ no	☐ yes _____
Hepatitis B or C	☐ no	☐ yes _____
HIV/AIDS	☐ no	☐ yes _____
Autoimmune disease	☐ no	☐ yes _____
Intestinal disease	☐ no	☐ yes _____

Please list your other **medical conditions** and **surgeries** (past or present, give dates): _____

_____

_____

Medications:

Please list all your medications, including **creams and ointments**: _____

_____

Allergies:

Please list any **drug or food allergies, or latex allergy:** _____

_____

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Family History:

Has anyone in the **immediate family** (brothers, sisters, parents) ever had the following?

Melanoma	☐ no	☐ yes _____
Abnormal moles	☐ no	☐ yes – state who _____
Genetic disease	☐ no	☐ yes – state who _____
Asthma	☐ no	☐ yes – state who _____
Psoriasis	☐ no	☐ yes – state who _____
Autoimmune disease	☐ no	☐ yes – state who _____
Atopic dermatitis (eczema)	☐ no	☐ yes – state who _____

Social History:

List occupations of: Mother _____ Father _____ Guardian _____

Parents are: ☐ married ☐ single ☐ divorced ☐ separated

Who lives in the household? _____

(*please list names and ages of siblings)*

What are child's hobbies (e.g. sports)? _____

What pets are in your home? _____

Review of Systems:

Please let us know if you suffer from any of the following:

Unexplained weight loss	☐ no	☐ yes	Nausea, vomiting	☐ no	☐ yes
Fevers, chills	☐ no	☐ yes	Anxiety	☐ no	☐ yes
Chronic headaches	☐ no	☐ yes	Depression	☐ no	☐ yes
Eye/visual problems	☐ no	☐ yes	Other psychiatric illness	☐ no	☐ yes
Chronic nasal congestion	☐ no	☐ yes	Easy bruising	☐ no	☐ yes
Chest pain	☐ no	☐ yes	Swollen glands	☐ no	☐ yes
Irregular heartbeat	☐ no	☐ yes	Joint pain/arthritis	☐ no	☐ yes
Wheezing, short of breath	☐ no	☐ yes	Chronically cold fingers/toes	☐ no	☐ yes
Abdominal pain	☐ no	☐ yes	Elevated blood sugars	☐ no	☐ yes

Signature of Parent/Guardian _____ **Date:** _____

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I hereby authorize the taking of photographs of my child by Hartford Dermatology Associates, Pediatric Dermatology Associates, or their designates. I understand that these may be used for documentation, educational lectures, and/or may be used for professional journals or medical textbooks as deemed appropriate by Hartford Dermatology Associates and/or Pediatric Dermatology Associates. I understand that my child's identity will remain anonymous and every effort will be made to ensure that he/she is unidentifiable from these photos.

Signature of Parent/Guardian _____ **Date**: _____

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We ask that in the event you need to cancel or reschedule your child's appointment, you kindly give us at least 24 hours notice. Please be advised that our office has a policy that after 3 missed appointments, patients will be unable to make further appointments or receive our care.

Signature of Parent/Guardian _____ **Date:** _____