

Patient Information & Medical History

Name: _____		Health Card #: _____	Version Code: _____
Last	First		
Address: _____		D.O.B: _____ / _____ / _____	Age: _____
Unit	Street	Day	Month
		Year	
City/Municipality _____		Postal Code _____	
Referred by: Dr. _____		Home Phone: _____	
Family Physician: Dr. _____		Work Phone: _____	
		Cell Phone: _____	
		E-mail Address: _____	
		Your occupation: _____	

For which skin problem were you referred? acne, rash, growth, warts, or other (please describe)

When did you first notice this skin problem? _____

Have you previously treated this problem with creams, pills, medications or soaps? Please list ANYTHING you have used: _____

Which body soaps do you use? _____

Which laundry soap, fabric softener and bleach do you use? _____

Do you use a sunscreen and, if so, which one? _____

Have you ever had skin cancer? Please specify _____

List any other skin problems you have had in the past: _____

List any medications (penicillin, aspirin, anesthetics, etc.) or any other substances (jewelry, poison ivy, etc.) to which you are allergic: _____

Do you now or have you ever had (please check if yes)? stomach ulcers HIV blistering sunburn

eczema hives easy bleeding Raynaud's disease allergy to cold temperatures

asthma hepatitis tuberculosis rheumatic fever glaucoma diabetes

seizures fainting high blood pressure pacemaker artificial joint artificial heart valve

Are you under the care of another doctor for any other condition? If yes, for which conditions? _____

Please list any pills, vitamins or herbal preparations (including aspirin and birth control pills) that you are taking: _____

Have any family members had (please check if yes and specify which family member(s))?
 melanoma _____ eczema _____ psoriasis _____

IF YOU ARE A WOMAN, are you pregnant or trying to get pregnant? Yes No Are you breast-feeding? Yes No

I give my permission for Dr. Guenther and her assistants to leave messages on my answering service. Yes No

I give my permission for Dr. Guenther and her assistants to review my chart for purposes of clinical research and I give my permission for them to contact me if I might benefit from potential new treatment(s). Yes No

Patient or Guardian signature: _____ Date signed: _____

PLEASE GIVE 24 HOUR CANCELLATION NOTICE

Due to a shortage of dermatologists, heavy patient demands and surgical procedures, a wait may be experienced. We appreciate your patience.