University Hospital
University of Missouri Health Care

Patient Name ____________________

Medical Record No ________________

Appointment Date ________________

Dermatology Clinic Patient Information Sheet

Site Name ____________________ Contact ____________ Phone ___________ Fax __________

✳ BEFORE appointment, fax COMPLETED form to Derm Clinic: (573) 884-0723 ✳

Name ______________________________ Date ____________________

Please circle any symptoms, sign, or conditions you are currently experiencing:

Fever	Nausea/vomiting	Mole changes	Itching	Skin rashes
Pregnancy	Diarrhea	New growth	Non-healing sores	
Tenderness	Other ____________			

Past Medical History/Family History

Disease	Yourself	Family	Disease	Yourself	Family
Acne	______	______	High cholesterol	______	______
Asthma/hay fever	______	______	Kidney disease	______	______
Bleeding disorder	______	______	Joint replacement	______	______
Depression	______	______	Liver dz/Hepatitis	______	______
Diabetes	______	______	Psoriasis	______	______
Eczema	______	______	Recurrent yeast inf	______	______
Fever blister	______	______	Skin Cancer	______	______
Heart or renal transplant	______	______	Heart valve dz/Murmur	______	______

What is your occupation?______________________________ Do you smoke? Yes No

What outdoor activities do you enjoy? ______________________________

Do you drink alcohol? Yes No How often? ______________________________

Do you wear sunscreen? Yes No Have you ever used a tanning bed? Yes No

Have you ever had blistering sunburn? Yes No Are you a student? Yes No

Are you planning a pregnancy? Yes No Date of last menstrual period ____________________

Current medications including non-prescription, allergy and birth control: ____________________

____

____

Preferred pharmacy ______________________ Pharmacy phone ______________

Daytime phone ____________________ Evening/cell phone____________________

Patient Signature ______________________________ Date ______________