

SUTTON PLACE DERMATOLOGY  
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Patient Form

Patient Information:

Name: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

SS #: \_\_\_\_\_ Sex:  M  F Occupation: \_\_\_\_\_

Name of Employer/School: \_\_\_\_\_

Address: \_\_\_\_\_

Emergency Contact: Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Medical History:

Please list any medications, vitamins or supplements that you are taking: \_\_\_\_\_

Have you ever recently discontinued a medication or supplement in the last 4 weeks, including aspirin, advil, or ibuprofen (Motrin): \_\_\_\_\_

Do you bruise easily? Y or N

Have you ever been allergic to a medication? Y or N

Please List:

Do you have any of the following conditions/illnesses?

Asthma Y or N Hay fever/Sinus Condition Y or N

Bleeding disorder Y or N Heart disease Y or N

Emphysema Y or N High Blood Pressure Y or N

Diabetes Y or N Cancer, If so what type \_\_\_\_\_

Hepatitis Y or N HIV Disease Y or N

Arthritis Y or N

Have you ever had an HIV test? Y or N

Have you ever had surgery? Y or N

Please indicate what type:\_\_\_\_\_

Are you allergic to any form of anesthetic (Novocain or Lidocaine)? Y or N

Do you smoke? Y or N

If yes, how much?\_\_\_\_\_

Dermatology History:

Have you ever had skin cancer? Y or N

Has anyone in your family ever had skin cancer? Y or N

Do you have any of the following conditions?

Psoriasis Y or N                      Eczema Y or N

Acne Vulgaris Y or N                Dry Skin Y or N

Hair Loss Y or N                      Abnormal Nail Growth Y or N

As part of your skin examination today a skin cancer screen may be performed. If there are any new moles/spots/growths on the skin please indicate area:\_\_\_\_\_

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