BABICH SKIN CARE CENTER
NEW PATIENT QUESTIONNAIRE

_____ _____ _____
Patient Name Date of Birth Age

_____ _____
Street Address City/State/Zip Code

_____ _____ _____
Home Telephone Work Telephone Occupation (1) / Occupation (2)

_____ _____
Hobbies List Household Pets

Did a doctor refer you? If yes, doctor's name and address: _____

How did you hear about our practice? _____

Please describe the **MAIN** reason for your visit today: _____

_____

Do you **CURRENTLY** experience any of the following symptoms:

Excessive fatigue	__Yes __No	Nausea	__Yes __No
Fever or Chills	__Yes __No	Blood in Urine	__Yes __No
Dry or itchy eyes	__Yes __No	Joint aches	__Yes __No
Mouth sores	__Yes __No	Muscle aches	__Yes __No
Dry mouth	__Yes __No	Problems healing	__Yes __No
Swollen glands	__Yes __No	Excessive sweating	__Yes __No
Shortness of breath	__Yes __No	Easy bruising	__Yes __No
Chest pain	__Yes __No	Varicose veins	__Yes __No
Trouble swallowing	__Yes __No		

1. List any **PERSONAL** history of **skin diseases** or **skin cancer**: _____

   _____

2. List any **medical illnesses** and all **medications** taken for those illnesses, including any over the counter medications taken regularly or as needed: _____

   _____

3. List any allergies to any medications:_____
4. List any contact allergies (jewelry, earrings, perfumes, etc): _____

   _____

5. Have you **EVER** had thickened scars? _____Yes _____No

TURN OVER AND COMPLETE OTHER SIDE

6. List any **FAMILY HISTORY** of skin cancer, skin diseases or medical problems :

   _____

7. List previous **surgeries**: _____
8. Miscellaneous:

Do you smoke? _____Yes How much? _____ How long? _____No_____ Quit ---When_____

Passive tobacco_____ Yes _____No How often _____

Do you drink alcohol? _____Yes _____No How many drinks per week?_____ How long _____

Do you use street drugs? _____Yes _____No What_____ How much_____ How often_____

Do you sunburn easily? _____Yes _____No

Do you have a history of blistering sunburns? _____Yes _____No

How much water do you drink daily? _____

How often do you wear sunscreen? _____Very little ____Moderate _____Quite a bit

What SPF is it? _____ Does it block UVA? _____

Names of skin & hair care products: (soaps, lotions, Shampoos, Makeup, etc.):

_____

_____

FEMALE PATIENTS:

Menstrual Cycles: _____Regular _____Irregular
Are you trying to get pregnant _____Yes _____No
Method of Birth Control: _____Pill _____Other
How many pregnancies: _____ Children's ages:_____

CHILDREN: Growth & development normal _____Yes _____No

_____ _____
Patient signature Date

_____ _____
Parent or legal guardian signature Date

_____ _____
Power of Attorney signature, if applicable Date