

Welcome
to the
Dermatology Clinic
at the
University of Iowa
Hospitals & Clinics

Name: _____
Date of Birth: _____
Phone: _____
Referring Physician: _____
Phone: _____

Did another health care provider ask you to be seen here?	YES	NO
If YES, what is his or her name? _____		

SKIN PROBLEM: check all that apply

<input type="checkbox"/> I am new to this Derm clinic	<input type="checkbox"/> Ongoing problem, followup	<input type="checkbox"/> New problem(s)
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REVIEW OF OTHER BODY SYSTEMS: check any that you are currently experiencing or have recently experienced.

<input type="checkbox"/> Fever	<input type="checkbox"/> Nausea	<input type="checkbox"/> Joint aches
<input type="checkbox"/> Weight loss	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Muscle aches
<input type="checkbox"/> Night sweats	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Fatigue/tiredness
<input type="checkbox"/> Chills	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Problems sleeping
<input type="checkbox"/> Are you pregnant?	<input type="checkbox"/> Are you breast-feeding?	

Preferred Pharmacy Information

Pharmacy Name: _____

Pharmacy Phone Number: _____

List of Current Medications

Medication Name	Dose	How many times a day do you take it?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SKIN REVIEW: check all that apply

<input type="checkbox"/> Excessive bleeding	<input type="checkbox"/> Excessive scarring	<input type="checkbox"/> Use tanning booths
<input type="checkbox"/> Problems healing	<input type="checkbox"/> Frequent sun exposure	<input type="checkbox"/> Nickel or other skin allergy

PAST MEDICAL HISTORY - Have you ever had, or do you currently have any of the following?

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer - type: _____	<input type="checkbox"/> Kidney/Bladder problems
<input type="checkbox"/> Liver disease/hepatitis	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Stomach/Bowel problems	<input type="checkbox"/> Blood clots
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hay fever	<input type="checkbox"/> Skin cancer/Melanoma
<input type="checkbox"/> Stroke	<input type="checkbox"/> Blood transfusions	<input type="checkbox"/> Artificial joint/heart valve
<input type="checkbox"/> Arthritis/Rheumatism	<input type="checkbox"/> Transplant	<input type="checkbox"/> Internal Pacemaker/Defib

Other medical history we should be aware of: _____

FAMILY HISTORY:

- No family history available
 Asthma Eczema Hay Fever Skin Cancer
 Cardiovascular disease Autoimmune disease Any hereditary disease

SOCIAL HISTORY:

On average, how many alcoholic beverages (glasses of wine/beer) do you use per week?

- 0 drinks 1-2 drinks 3-6 drinks 7-14 drinks 16-25 drinks

On average, how many packs of cigarettes do you smoke each day?

- 0 packs Less than 1 pk 1-2 pks 2+ pks
 Use chewing tobacco/pipe/cigars

What is your current occupation? _____

 SIGNATURE OF PERSON COMPLETING FORM

 RELATIONSHIP TO PATIENT

Please fax completed form to:

Clinical Outreach Scheduling
 FAX: 319-353-8447