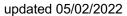
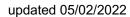


Patient Information							
I ast Name			First	Middle Initial			
Date of Birth /	/	Sex: M	First Middle Initial M F Preferred Contact Phone #				
Address							
City	Sta	ite	Zip	Email			
Emergency Contact I	Name/	Relation	ship	Phone	#		
Do you prefer we del	iver te	st result	s to vou	, emergency contact or bo	, th?		
Emergency contact n							
Primary Care Physici	an			PCP Phone #			
Primary Care PhysicianLoc				ation Phone#			
Referring Physician (if any)						
		M	ledical H	istory			
Have you been diagr	need	with or h	nad any of	the following conditions/treatn	nents?	,	
riave you been diagr	10300	with Of 1	iad arry or	the following conditions/treatil	iiciito:		
Diabetes mellitus	yes	no		Depression	yes	no	
Heart disease	yes	no		Anxiety	yes	no	
High blood pressure	yes	no		Pacemaker/defibrillator	yes	no	
High cholesterol	yes	no		Other Implanted device	yes	no	
Dementia	yes	no		Artificial joints	yes	no	
Arrythmia	yes	no		Pre-dental work antibiotics	yes	no	
Fainting/syncope	yes	no		Artificial heart valves	yes	no	
Asthma	yes	no		Arthritis	yes	no	
COPD	yes	no		Bleeding disorder	yes	no	
Thyroid disease	yes	no		Clotting disorder	yes	no	
Kidney disease	yes	no		Anticoagulant treatment	yes	no	
Memory problems	yes	no		Cancer	yes	no	
Crohn's disease	yes	no		Lymphoma	yes	no	
Ulcerative colitis	yes	no		Leukemia	yes	no	
Lupus	yes	no		Organ transplant	yes	no	
Psoriasis	yes	no		MRSA	yes	no	
Eczema	yes	no		Immunosuppression	yes	no	
Hay fever	yes	no		HIV Positive	yes	no	
Cold sore/HSV	yes	no		Hepatitis	yes	no	
Hearing Loss	yes	no		Autism	yes	no	
MS/ALS/neurologic d	-	e yes	no	Other:	-		
				No	NOP.		
				Name	OB		





Women's only history:						
Are you pregnant? yes no						
If yes, how many weeks pregnant are you?						
Are you currently nursing? yes no						
Are you currently using any form of pregnancy contraception? yes no						
If yes, please list the form (oral, intra-uterine, implantable, etc):						
, ,						
Skin Cancer History						
Do you have a personal history of melanoma? yes no						
Do you have a family history of melanoma? yes no						
Relationship:						
Do you have a personal history of non-melanoma skin cancer (for example, basal cell						
carcinoma, squamous cell carcinoma etc., other skin cancer)? yes no						
If yes, please list the skin cancer type:						
Managara Cana						
Vaccinations						
And warm improved in the state O						
Are your immunizations up to date? yes no						
Have you received the influenza vaccine? yes no						
Have you received the shingles/herpes zoster vaccine? yes no						
Have you received the Covid vaccine? yes no						
Allergies						
Allergies						
Do you have any known medication, adhesive or other allergy? yes no						
If the answer is No, you may skip to the section titled Current Medications.						
Do you have an allergy to lidocaine? yes no						
Do you have an allergy to indocaine? yes no						
Do you have an allergy to latex? yes no						
Do you have an allergy to latex! yes no						
Please list any known allergies below:						
Tiedse list arry known allergies below.						
						
						
						
Current Medications						
18						
29						
3 10 1						
411						
Name DOB						





5			_ 12		
6			_ 13		
7			_ 14		
•		pplements (ie. prenatal list below:	, vitamin 	D, St. John's wo	rt)? yes no
		Past Sur	gical His	tory	
Type of surge (Include Left)	•	t side when appropriat	te) 	Year	_
					_ _
		Socia	I History	<i>I</i>	
If yes, Do you engag Do you drink If yes, Have you had Have you had Do you use s	please ge in re alcoho how m d expos d bliste unscre	w many years have you list the number of pactoreational drug use? It? yes no any alcoholic beverage are to tanning beds? Iring sun burns in the pen regularly? yes required wisit:	ks you sn yes no es do you yes no ast? ye	noke per day: o consume per w o s no	eek?
Are vou curr	ently h	naving any of the follo	owina sv	mptoms?	
Fever	yes	no	g c,	Joint pain y	es no
Chills	yes	no		Muscle aches	yes no
Fatigue	yes	no		Headache	yes no
Weight loss	yes	no		Easy bruising	yes no
Chest pain	yes	no		Rash/itch	yes no
Abdominal pa		es no		Swollen lympl	
Nausea	yes	no		Eye pain or di	scomfort yes no
Vomiting	yes	no		Diarrhea	yes no
Shortness of	breath	or difficulty breathing	yes or	no Cough	yes no
				Name	DOB

Name_____DOB____



We would also love to hear how you heard about the practice? This is important so we can learn the best ways to integrate into and serve our community!

Referred by primary care physician		
Referred by family/friend:	-	
Social Media (Facebook, Toledo Clinic adds)		
Other:	-	
Appointment No-Show, Change	& Cancell	ation Policy
Nahhas Dermatology at the Toledo Clinic strives to care and respects patient's time in our office. Our change or cancel a medical appointment and 48-happointments. Patients arriving more than 20 minutes after the appointments arriving more than 20 minutes after the appointments arriving more than 20 minutes after the appointments and \$75 for cosmetic service appointments and \$75 for cosmetic service appointments will require conservice procedure appointments will require conservice appointment and 48-hour notice during business hours	office will reconour notice for ppointment s appointments. omplete pay make your a	tart time may have to
This policy allows our office to function with efficie our patients.	ncy and prov	ride the best care to all of
Please sign date and time to communicate accept	tance of this	policy.
Signature here	Date	Time