CHILD

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Greater Nebraska Dermatology Clinic PC

Dermatology New Patient Intake Form

All questions contained in this questionnaire are strictly confidential.

Patient name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Did your physician refer your child to Dermatology? If yes, please list the name of the referring physician _____	
What is the reason for your visit today?	
How long have you had this problem?	
Where on your body is the problem located?	
What treatments have you tried so far?	

Does it itch?	☐ **Yes**	☐ **No**
Does it hurt?	☐ **Yes**	☐ **No**

PERSONAL HEALTH HISTORY

List any past or current medical problems that other doctors have diagnosed:

Surgeries and/or other hospitalizations

Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Drug Name	Strength	Frequency taken

Allergies to medications

Drug Name	Reaction

Have you experienced any of the following symptoms in the last month?		
High or frequent fever	☐ **Yes**	☐ **No**
Fatigue	☐ **Yes**	☐ **No**
Change in appetite	☐ **Yes**	☐ **No**
Significant change in weight	☐ **Yes**	☐ **No**
Runny nose	☐ **Yes**	☐ **No**
Cough	☐ **Yes**	☐ **No**

*Continued...*Have you experienced any of the following symptoms in the last month?		
Sore throat	☐ Yes	☐ No
Excessive sweating	☐ Yes	☐ No
Stomach pain	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Change in sleep	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Blood in urine or stool	☐ Yes	☐ No
Nausea or vomiting	☐ Yes	☐ No
Joint aches or swelling	☐ Yes	☐ No
Inability to tolerate heat/cold	☐ Yes	☐ No
FAMILY HEALTH HISTORY		
Is there anyone in your family with any of the following conditions? If yes, please indicate who		
Skin cancer	☐ Yes	☐ No
Abnormal moles	☐ Yes	☐ No
Eczema	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Seasonal allergies	☐ Yes	☐ No
Psoriasis	☐ Yes	☐ No
Thyroid disease	☐ Yes	☐ No
Vitiligo	☐ Yes	☐ No
Alopecia areata	☐ Yes	☐ No
Rheumatoid arthritis	☐ Yes	☐ No
Lupus	☐ Yes	☐ No
Diabetes - Type 1 or Type 2	☐ Yes	☐ No
SOCIAL HISTORY		
Parents marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Patient resides/lives: _____ With parents _____ Other:		
Do you have siblings? If so, how many?		
What grade are you in?		
What are your interests?		
Is there tobacco use in the home?	☐ Yes	☐ No
IF YOU ARE HERE FOR ECZEMA OR ACNE, PLEASE ANSWER THE FOLLOWING:		
What kind of soap/cleanser do you use (body and/or face)?		
What kind of moisturizer do you use (body and/or face)?		
How often are you applying moisturizer in a single day?		
How often do you bathe in a single week?		