Northwestern Medicine®

Glenview Outpatient Center

Department of Dermatology

Name: _____ Date of Birth: _____

Referring Physician (with location or fax number):_____

Primary care physician (with location or fax number):_____

Reason for visit:_____

Active medical issues:

1.	4.	7.
2.	5.	8.
3.	6.	9.

Past medical issues:

1.	4.	7.
2.	5.	8.
3.	6.	9.

Do you or a family member have a history of (please check all that apply):

	SELF	RELATIVE
Melanoma		
Other skin cancer		
Psoriasis		
Eczema		
Other cancer		

Family history of medical issues:

1.	3.	5.
2.	4.	6.

Current medications (without dosing):

1.	4.	7.
2.	5.	8.
3.	6.	9.

Drug allergies:

1.	3.
2.	4.

Do you have any of the following (please circle all that apply):
Fevers, chills, night sweats, chest pain, incontinence, burning with urination, blood in urine, headaches, numbness, tingling, seizures, shortness of breath, depression, anxiety, sore throats, diarrhea, constipation, nausea, vomiting, abdominal pain, joint pain, muscle aches

Do you smoke, how much: _____ Do you use alcohol, how often: _____

Occupation:_____ Marital status: single married divorced widowed

Preferred pharmacy(zip code or phone number): _____