Seitz Dermatology
2112 Seymour Avenue
Cheyenne, WY 82001

Patient Information Form

Name: First _____ M.I _____ Last _____

Date of Birth _____ Sex: ☐ Male ☐ Female Home Phone: _____ Work Phone: _____

Pharmacy: _____ Pharmacy Phone: _____

Referring Physician: _____ Phone Number: _____

Allergies to Medications: ☐ None 1. _____ Reaction: _____

2. _____ Reaction: _____

Current Medications: ☐ None 1._____ 2._____ 3._____

4._____ 5._____ 6._____

	YES NO		YES NO		YES NO
Aspirin/Motrin/Advil	☐ ☐	Birth Control	☐ ☐	Are you pregnant	☐ ☐
Coumadin	☐ ☐	Are you breast feeding	☐ ☐	Plan on becoming Pregnant	☐ ☐

Review of Systems Screen (Current or Past problems with)

	YES NO		YES NO		YES NO		YES NO
Blood/Bleeding Disorders	☐ ☐	Arthritis	☐ ☐	Cancer (non-skin)	☐ ☐	Melanoma	☐ ☐
Heart Disease	☐ ☐	Diabetes (sugar)	☐ ☐	Immunologic Disease	☐ ☐	Thyroid Disease	☐ ☐
Kidney Disease	☐ ☐	High Blood Pressure	☐ ☐	Latex/Rubber/Nickel/Food	☐ ☐	Lung Disease	☐ ☐
Liver Disease or Hepatitis	☐ ☐	Infectious disease (TB, HIV)	☐ ☐	Skin Disease	☐ ☐	Skin Cancer	☐ ☐
Received Blood Transfusions	☐ ☐	Psychological Disorders	☐ ☐				

Do you	**YES NO**
Have a pacemaker or defibrillator	☐ ☐
Have an artificial joint or heart valve	☐ ☐
Take antibiotics prior to surgical procedures	☐ ☐

List Surgeries:

1._____

2._____

3._____

Other medical problems (explain):_____

Family History (Check the following medical conditions which have occurred in your family:)

Disease	Mother	Father	Blood Relative	None	Disease	Mother	Father	Blood Relative	None
Acne	☐	☐	☐	☐	Hay Fever	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	Hives	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	Lupus	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	Melanoma	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	Psoriasis	☐	☐	☐	☐
Eczema	☐	☐	☐	☐	Skin Cancer	☐	☐	☐	☐

Social History	**YES NO**	
Do you live alone?	☐ ☐	
Do you drink alcohol?	☐ ☐	Frequency_____
Do you smoke or use tobacco products?	☐ ☐	Frequency_____
Are you a former smoker or tobacco user?	☐ ☐	

Patient signature_____ Date:_____