The Toledo Clinic | Nahhas Dermatology

updated 05/02/2022

Patient Information

Last Name _____ First _____ Middle Initial _____
Date of Birth___/___/____ Sex: M F Preferred Contact Phone # _____
Address _____
City _____ State _____ Zip_____ Email_____

Emergency Contact Name/Relationship_____ Phone#_____
Do you prefer we deliver test results to ☐ you, ☐ emergency contact ☐ or both?
Emergency contact must be listed on your HIPAA paperwork.

Primary Care Physician_____ PCP Phone #_____
Preferred Pharmacy_____ Location _____ Phone# _____
Referring Physician (if any) _____

Medical History

Have you been diagnosed with or had any of the following conditions/treatments?

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 disease	☐ yes ☐ no	Other: _____	

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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: _____

Vaccinations

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

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 epinephrine? ☐ yes ☐ no

Do you have an allergy to latex? ☐ yes ☐ no

Do you have an allergy to adhesive tape? ☐ yes ☐ no

Please list any known allergies below:

_____ _____

_____ _____

_____ _____

Current Medications

1._____ 8. _____

2._____ 9._____

3._____

Name_____ DOB_____

10._____
4._____ 11._____
5._____ 12._____
6._____ 13._____

7._____ 14. _____

Do you take any supplements (ie. prenatal, vitamin D, St. John's wort)? ☐ yes ☐ no
If yes, please list below:

_____ _____
_____ _____

Past Surgical History

Type of surgery *(Include Left or Right side when appropriate)*	Year
_____	_____
_____	_____
_____	_____

Social History

Do you use tobacco? ☐ yes ☐ no
Do you smoke cigarettes? ☐ yes ☐ no
If yes, for how many years have you smoked? _____
If yes, please list the number of packs you smoke per day: _____
Do you engage in recreational drug use? ☐ yes ☐ no
Do you drink alcohol? ☐ yes ☐ no
If yes, how many alcoholic beverages do you consume per week? _____
Have you had exposure to tanning beds? ☐ yes ☐ no
Have you had blistering sun burns in the past? ☐ yes ☐ no
Do you use sunscreen regularly? ☐ yes ☐ no

Reason for today's visit: _____
_____

Are you <u>currently</u> having any of the following symptoms?

Fever ☐ yes ☐ no
Chills ☐ yes ☐ no
Fatigue ☐ yes ☐ no
Weight loss ☐ yes ☐ no
Chest pain ☐ yes ☐ no
Abdominal pain ☐ yes ☐ no
yes ☐ no

Joint pain ☐ yes ☐ no
Muscle aches ☐ yes ☐ no
Headache ☐ yes ☐ no
Easy bruising ☐ yes ☐ no
Rash/itch ☐ yes ☐ no
Swollen lymph nodes ☐

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Nausea ☐ yes ☐ no Eye pain or discomfort ☐ yes ☐ no
Vomiting ☐ yes ☐ no Diarrhea ☐ yes ☐ no
Shortness of breath or difficulty breathing ☐ yes or ☐ no Cough ☐ yes ☐ no

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 & Cancellation Policy

Nahhas Dermatology at the Toledo Clinic strives to provide the highest level of patient care and respects patient's time in our office. Our office will require **24-hour** notice to change or cancel a medical appointment and **48-hour** notice for cosmetic service appointments.
Patients arriving more than 20 minutes after the appointment start time may have to reschedule. The **no-show fee is $50 for medical appointments, $200 for surgical appointments and $75 for cosmetic service appointments. Certain cosmetic service procedure appointments will require complete payment in advance. Payment is nonrefundable if you are unable to make your appointment without giving a 48-hour notice during business hours.**

This policy allows our office to function with efficiency and provide the best care to all of our patients.

Please sign date and time to communicate acceptance of this policy.

Signature here_____ Date_____Time_____

Name_____ DOB_____