The Toledo Clinic | Nahhas Dermatology

updated 11/30/2023

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.

Would you like to be added to our mailing list & Birthday Club? • yes • no

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
Heart disease • yes • no
High blood pressure • yes • no
High cholesterol • yes • no
Dementia • yes • no
Arrythmia • yes • no
Fainting/syncope • yes • no
Asthma • yes • no
COPD • yes • no
Thyroid disease • yes • no
Kidney disease • yes • no
Memory problems • yes • no
Crohn's disease • yes • no
Ulcerative colitis • yes • no
Lupus • yes • no
Psoriasis • yes • no
Eczema • yes • no
Hay fever • yes • no
Cold sore/HSV • yes • no
Hearing Loss • yes • no
MS/ALS/neurologic disease • yes • no

Depression • yes • no
Anxiety • yes • no
Pacemaker/defibrillator • yes • no
Other Implanted device • yes • no
Artificial joints • yes • no
Pre-dental work antibiotics • yes • no
Artificial heart valves • yes • no
Arthritis • yes • no
Bleeding disorder • yes • no
Clotting disorder • yes • no
Anticoagulant treatment • yes • no
Cancer • yes • no
Lymphoma • yes • no
Leukemia • yes • no
Organ transplant • yes • no
MRSA • yes • no
Immunosuppression • yes • no
HIV Positive • yes • no
Hepatitis • yes • no
Autism • 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: _____

Have you had blistering sunburns in the past? • yes • no

Have you had exposure to tanning beds • yes • no

Do you use sunscreen regularly? • yes • no

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:

_____ _____

_____ _____

_____ _____

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Current Medications

1._____ 8. _____
2._____ 9._____
3._____ 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? _____
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
Nausea • yes • no
Vomiting • yes • no
Shortness of breath or difficulty breathing • yes or • no
Joint pain • yes • no
Muscle aches • yes • no
Headache • yes • no
Easy bruising • yes • no
Rash/itch • yes • no
Swollen lymph nodes • yes • no
Eye pain or discomfort • yes • no
Diarrhea • yes • no
Cough • yes • no

Name_____ DOB_____

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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, is dedicated to delivering the highest standard of patient care while valuing our patients' time. To facilitate efficient scheduling and ensure optimal care, we kindly request:

- A 24-hour notice for changes or cancellations of medical appointments.
- A 72-hour notice for any procedure or surgical appointment.

As our commitment to punctuality, patients arriving more than 20 minutes after their scheduled appointment time may need to reschedule.

Our policy regarding missed appointments includes:

- A $50 no-show / late cancellation fee for medical appointments.
- A $200 no-show / late cancellation fee for surgical appointments.
- Patients who miss two appointments will not be rescheduled.

To modify or cancel your appointment, please contact us at 567-420-2526.

We appreciate your cooperation and understanding regarding these policies, which help us maintain our commitment to exceptional patient care and scheduling efficiency.

Please sign, date and time to communicate understanding of this policy.

Signature here_____ Date_____Time_____

O: 567.420.2526 | F: 567.420.2537
4235 Secor Road, Bldg. 1 - Upper
Toledo, Ohio 43623

Name_____ DOB_____