250 Harding Blvd W, Suite #312, Richmond Hill, ON L4C 9M7
905.883.7997 tel - 905.883.7994 fax
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Dr. Sanjay Siddha, M.D., F.R.C.P.C | Dr. Afsaneh Alavi, M.D., F.R.C.P.C

NEW PATIENT INTAKE QUESTIONNAIRE

Last Name: ______________________ First Name: ______________________

Address: ____

City: ______________________ Postal Code: ______________________

Home Phone: ______________________ Work/Cell: ______________________

Email address: ____

Sex: M _____ F _____ Birth Date: Day _____ Month _____ Year _____

Occupation: ______________________ Employer: ______________________

Health Card No: ______________________ Health Card No: ______________________

Family Card No: ____

Family Doctor: ______________________ Referring Dr: ______________________

Do you have a drug / insurance plan? Yes ________ No ________

YOUR DERMATOLOGICAL HISTORY

Reason for your visit? ____

Main areas of the body involved: ____

How long have you had it? ____

Have you had the same problem before? Yes _____ No _____ If yes, when: ______________________

____

Previous skin problems? Yes _____ No _____ If yes, describe: ______________________

____

History of skin cancer? Yes _____ No _____ If yes, indicate: ______________________

Type: ______________________ When: ______________________

Where on the bod? ____

Family history of skin cancer? ____

____

____

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MEDICAL HISTORY

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Medical History: ____

____

Surgical History: ____

____

Medications you are on: ____

____

Are you on blood thinner (Coumadin, Plavix, ASA, other)? Yes _____ No _____

Allergic to any Medications? Yes _____ No _____ If yes, please list: ______________________

____

FEMALE PATIENTS ONLY:

Are you on birth control: Yes _____ No _____

Pregnant? Yes _____ No _____

FAMILY HISTORY:

Does anyone else in your family have skin problems? Yes _____ No _____

If yes, please indicate which of the family member and the type of problem: ______________________

____

____

Today's Date: ______________________

Signature: ______________________