

Please fill out black lines only. **DO NOT FILL OUT RED** (Nurse will fill out at appointment).
Please PRINT CLEARLY as this will be a part of your permanent medical records.

NEW RETURN REFERRED BY: _____ ROOM # _____

REASON FOR APPOINTMENT AT OWENSBORO DERMATOLOGY: _____

HOW LONG HAS THIS CONDITION BEEN PRESENT? _____

WHAT ARE YOUR SYMPTOMS, IF ANY (ITCHING, BURNING, BLEEDING, ETC)?

PLEASE LIST: _____

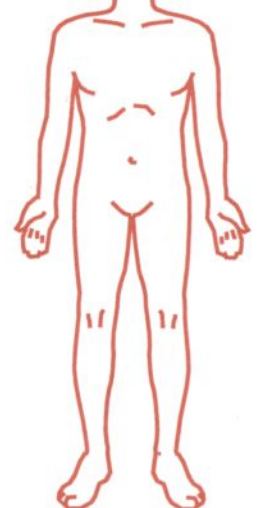
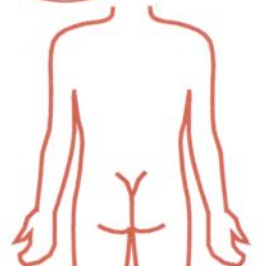
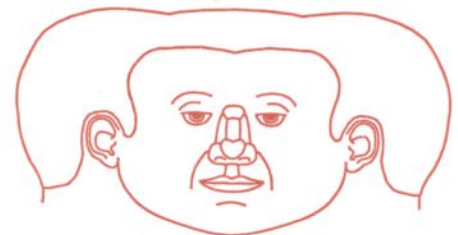
PLEASE LIST THE NAMES OF PRESCRIPTION AND OVER THE COUNTER MEDICATIONS
THAT HAVE BEEN USED TO TREAT YOUR CONDITION (TOPICALLY - CREAMS/
OINTMENTS, ORALLY - PILLS) AND THEIR RESULTS? (YOU MAY NEED TO CALL
YOUR PHARMACY TO GET THE NAMES AND CORRECT SPELLINGS OF PREVIOUS
MEDICATIONS TRIED): _____

ALLERGIES TO MEDICATIONS: _____

CHANGES FROM LAST VISIT: _____

NOTES:

ASSISTANT _____



PATIENT: _____ DOB: _____ AGE: _____ DATE: _____ CHART# _____