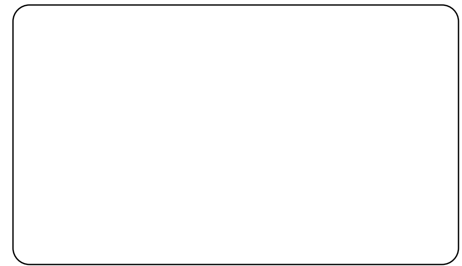
Boston Dermatology and Laser Center

New Patient Form

30 Lancaster Street Boston, MA 02114
Tel: 617-722-4100 | Fax: 617-227-1134 | www.bostondermandlaser.com



Patient Information		
Name *First* *Last* *M.I.*		
Social Security #	**Sex**	**DOB** _____/_____/_______ *MM DD YYYY*
Address *Street* *City* *State* *ZIP*		
Cell Phone	**Home Phone**	
Work Phone	**Email**	
Employer	**Occupation**	
Marital Status ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	**Spouse's Name**	
Primary Care Physician *Name* *Phone Number*		
Preferred Pharmacy *Name* *Street* *City* *State* *ZIP*		
Emergency Contact *Name* *Relation to Patient* *Phone Number*		

Reason for Visit

Current Medications	Allergies
Name *Dose*	
Name *Dose*	
Name *Dose*	
Name *Dose*	
Name *Dose*	
Name *Dose*	
Name *Dose*	
Name *Dose*	
Name *Dose*	

PLEASE SEE OTHER SIDE →

Skin

Do you have any of the following?

☐ Abnormal/Changing Moles ☐ Acne ☐ Boils ☐ Bleed Easily ☐ Cold Sores ☐ Dry/Sensitive Skin ☐ Eczema ☐ Hives
☐ Itching ☐ Non-healing Sores ☐ Psoriasis ☐ Rash ☐ Rosacea ☐ Scars ☐ Warts ☐ Other ___________________

Details

When you are exposed to the sun do you:
☐ Tan Only ☐ Tan and Burn ☐ Burn Only

Have you ever used a tanning booth? ☐ Yes ☐ No
If yes, do you currently? ☐ Yes ☐ No

Do you wear sunscreen? ☐ Yes ☐ No
If yes, what SPF?

Have you ever had skin cancer? ☐ Yes ☐ No ☐ Don't Know

If yes, what type(s), where, and when?

____
Type(s) *Location(s)* *Year(s)*

____
Type(s) *Location(s)* *Year(s)*

Personal Medical History

Have you ever had any of the following?

☐ Alcoholism	☐ Bowel Disorder	☐ Heart Problems	☐ Liver Disorder	☐ Rheumatic Fever
☐ Anemia	☐ Cancer	☐ Hepatitis (A, B, or C)	☐ Lung Disease	☐ Sinus Problems
☐ Anxiety Disorder	☐ Diabetes	☐ High Blood Pressure	☐ Lupus	☐ Stroke
☐ Asthma	☐ Depression	☐ High Cholesterol	☐ Measles	☐ Stomach Ulcer
☐ AIDS/HIV	☐ Eating Disorder	☐ Infectious Disease	☐ Migraines	☐ Substance Abuse
☐ Blood Disease	☐ Epilepsy	☐ Joint Disorder	☐ Osteoporosis	☐ Thyroid Disorder
☐ Blood Transfusion	☐ Heart Disease	☐ Kidney Disorder	☐ Pacemaker	☐ Tuberculosis

Details

Lifestyle Factors

Smoking Tobacco Status
☐ Current Every Day Smoker
☐ Current Some Day Smoker
☐ Former Smoker
☐ Never Smoked

Smokeless Tobacco Status
☐ Current User
☐ Former User
☐ Never Used

Do you drink alcohol? ☐ Yes ☐ No
If yes, how much per week?

Women Only

Are you currently pregnant? ☐ Yes ☐ No
If yes, how many weeks?

Are you trying to get pregnant? ☐ Yes ☐ No
Are you breastfeeding? ☐ Yes ☐ No

Surgical History

Surgery	Date

Family History

Has anyone in your family ever had any of the following?	If yes, who?
☐ Abnormal Moles	______________
☐ Acne	______________
☐ Asthma	______________
☐ Basal Cell Carcinoma	______________
☐ Cancer	______________
☐ Diabetes	______________
☐ Eczema	______________
☐ Hair Loss	______________
☐ Melanoma	______________
☐ Psoriasis	______________
☐ Skin Cancer	______________
☐ Squamous Cell Carcinoma	______________

I consent to receive text messages or emails regarding schedule updates, offers and events. I am aware I have the ability to opt-out at any time by calling the office. I understand Boston Dermatology and Laser Center reserves the right to charge a fee for any scheduled visits that are cancelled with less than 24 hours notice or are missed without notice (no show).

______________________________________ ______________
Signature of Patient (or Guardian if Minor) Date