NIKKO
DERMATOLOGY

Patient Information Forms

Please legibly print the following information on the front and back in black ink

Patient Name: ____
Last First Middle

Home Address: ____
Street & Apt. City State Zip

Home Phone: ________________ **Cell:** ____________________ **Work:** ________________

Date of Birth: ______________ **Gender:** _______ **E-mail:** ____________________________

Marital Status: Single _____ **Married (Spouse's Name):** ____________________________

Emergency Contact: ______________________________ **Relationship:** ________________
(Name)

Contact Phone: ________________________ **Alternate Phone:** ________________________

I will be using insurance for my dermatology appointment: ______ NO ______ YES

Referral Source (check all that apply):

______ Social Media ______ Website / Web Search ______ Magazine ______ Word of Mouth

______ TV Commercial ______ Yellow Pages ______ Radio ______ Other

Patient that we can thank for referring you (Name): ____

Nikko
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NAME:____ **DATE:**___/___/_____

DATE OF BIRTH: ___/___/____ Name I prefer to be called: ____________________

PAST MEDICAL HISTORY (Please **circle** all that apply)

Anxiety	End Stage Renal Disease	Leukemia or Lymphoma
Depression	Hearing Loss	Radiation Treatment
Arthritis	Heart Attack/Stroke	Pacemaker
Artificial Joints	Hepatitis B or C	Cancer:______________________
Diabetes	HIV/AIDS	Other:______________________
None of the Above		

PAST SKIN DISEASE HISTORY (Please **circle** all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratoses	Melanoma	Vitiligo
Pancreatic Mole	Asthma	Hayfever/Allergies
Eczema	Flaking or Itchy Scalp	Psoriasis
Basal Cell Carcinoma	Squamous Cell Carcinoma	Melanoma
None of the Above	Other____	

PAST SURGICAL HISTORY (Please **circle** all that apply)

Heart Valve Replacement	Skin Biopsy	Melanoma Surgery
Squamous Cell Carcinoma Surgery	Basal Cell Carcinoma Surgery	Lumpectomy
Masectomy	Joint Replacement ____________	Cosmetic surgery
Other: ______________________	None of the above	

Do you wear Sunscreen? Yes No
If Yes, what SPF?____________ how often? daily sometime only at the beach

FAMILY HISTORY (Please circle all that apply)

- □ Do you have an immediate family history of melanoma? **Yes** or **No**. If yes (Mother Father Sister Brother or Child)
- □ Are there any pertinent or major skin problems that run in your family? ______________________________

SOCIAL HISTORY:

- □ Currently Smokes? Yes or No, if yes- how many____Cigarette a day, for how many year?__________________
- □ Alcohol? Yes or No, if yes, how many drinks daily?______________________________________
- □ Are you on any kind of diet? Yes or No, If yes what diet?___________________________________
- □ What is your current and/or former occupation? ____
- □ What type of outdoor activities, if any, do you participate in? _____________________________
- □ Do you have any other hobbies or activities you would like us to know about? __________________
- □ Do you have any children or pets? ____
- □ With whom, if anyone, do you live? ____
- □ Where do you live (generally speaking: what town or city or county, assisted living facility)? ____________

____

- □ Are you currently using any dermatology lotion for skin care? Yes or No, if yes what product?____________
- □ Are you interested in cosmetic surgery? Yes or No______________________________________

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Do you have any other rashes? YES or NO
Do you have any problems with allergy or your immune system? YES or NO
Do you have any stress? YES or NO, If yes, how significant?____
Do you have problems with scarring? YES or NO
Do you have problems with bleeding? YES or NO

SYSTEMS REVIEW

Do you have any of the following complaints?

GENERAL

Fatigue ☐NO ☐YES
Weight loss ☐NO ☐YES
Weakness ☐NO ☐YES
Swollen Lymph nodes ☐NO ☐YES
Easy bruising ☐NO ☐YES

HEAD

Visual problems ☐NO ☐YES
Ear pain, decreased hearing ☐NO ☐YES
Difficulty swallowing ☐NO ☐YES
Severe headaches ☐NO ☐YES
Strokes ☐NO ☐YES
Other ______________________________

MEN ONLY

Hair growth or loss ☐NO ☐YES
Discharge from penis ☐NO ☐YES
Sore on penis ☐NO ☐YES
Other______________________________

CHEST, HEART AND LUNGS

Shortness of breath ☐NO ☐YES
Chest pain or pressure attacks ☐NO ☐YES
Frequent cough ☐NO ☐YES
Swollen ankles ☐NO ☐YES
Other______________________________

GASTROINTESTINAL

Poor appetite ☐NO ☐YES
Indigestion or vomiting ☐NO ☐YES
Change in bowel habits ☐NO ☐YES
Pass blood from rectum ☐NO ☐YES
Other______________________________

ENDOCRINE

Thyroid condition ☐NO ☐YES
Diabetes ☐NO ☐YES
Other ☐NO ☐YES

GENITALIA (WOMEN ONLY)

Breast lump ☐NO ☐YES
Discharge from nipple ☐NO ☐YES
Vaginal discharge or spotting (not from period) ☐NO ☐YES
Hot flashes ☐NO ☐YES
Change in periods ☐NO ☐YES
Are your periods irregular? ☐NO ☐YES
Possibly Pregnant? ☐NO ☐YES

KIDNEY

Difficulty in passing urine ☐NO ☐YES
Getting up at night to urinate ☐NO ☐YES
Other______________________________

NEUROMUSCULAR

Weakness in arms or legs ☐NO ☐YES
Loss of muscle strength ☐NO ☐YES
Fainting spells ☐NO ☐YES
Other______________________________
____

BONES/JOPINTS

Painful or swollen ankles ☐NO ☐YES
Loss of muscle strength ☐NO ☐YES
Prosthetic bone replacements ☐NO ☐YES
Back pain ☐NO ☐YES
Other______________________________

PSYCHIATRIC

Nervousness ☐NO ☐YES
Depression ☐NO ☐YES
Anxiety ☐NO ☐YES

MEDICATIONS (Please List any medications, including vitamins and supplements, doses & frequencies, tablet or liquid)

Medications	Doses	Directions

ALLERGIES TOP MEDICATIONS (Please list any medication allergies and the **type of reaction** that occurred)

____

PHARMACY (Please provide the pharmacy name, phone#, and address)

____

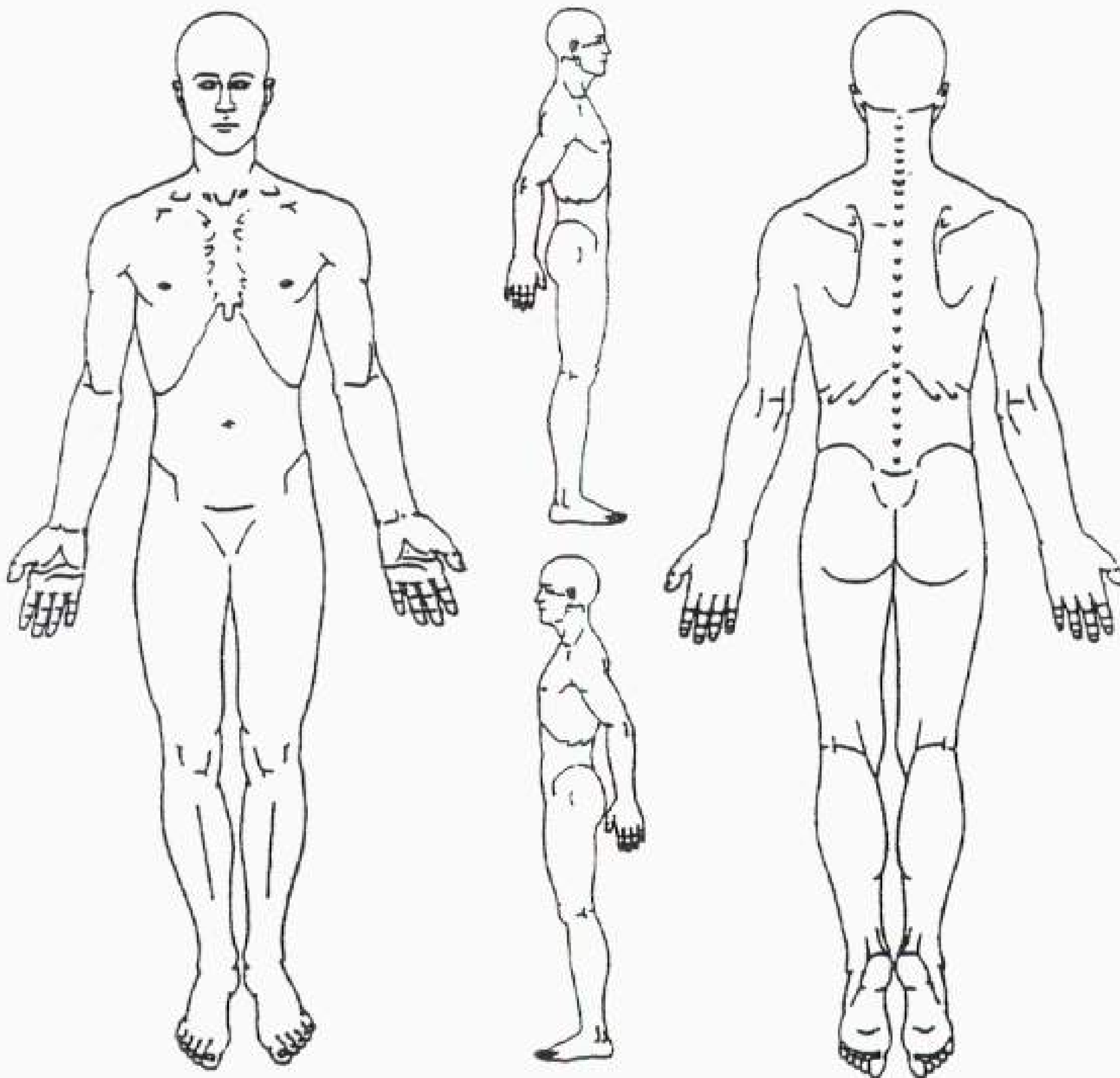
PRIMARY CARE DOCTOR: ____________________ **REFERRING DOCTOR:** ____________________

DERMATOLOGY ALERTS (Please **circle** any of these important alerts if they apply to you)

Allergy to topical antibiotic	Artificial heart valve	Defrillator
Rapid heartbeat with epinephrine	Artificial joints within last 2 years	Pacemaker
Allergy to adhesive	Premedication prior to procedures	Pregnant, planning or nursing
Allergy to Lidocaine	Blood thinners	Other: ____________

PLEASE DETAIL THE REASON FOR TODAY'S VISIT

Location: (Mark Site on chart below)



Problem: ______________________________

____

Quality: Symptomatic

Itch bleed tender scaly rough darker enlarging

Severity: **mild** **moderate** **severe**

____

Duration: How Long? ____________________

____

Previous Treatments: (Lotions, OTC, Prescription or other?)

____

What makes it better or worse? ____________

____

____

Health Assessment for Women

Name: ______________________ Date: ______________

Mail: ______________________

SYMPTOMS (Please Check Box)	Never	Mild	Moderate	Severe
1) Fatigue				
2) Mood Changes: Irritability Anxiety / Nervousness Depression				
3) Decreased Mental Ability: Memory Loss Confusion Loss of Focus				
4) Hot Flashes / Night Sweats				
5) Weight Gain: Bloating Excessive Belly Fat Inability to Lose Weight				
6) Decreased Sex Drive: Vaginal Dryness				
7) Sleep Problems: Can't Stay Asleep Can't Fall Asleep				
8) Cold Hands & Feet / Always Cold				
9) Hair loss / Breakage				
10) Dry Wrinkled Skin				

FAMILY HISTORY (Please Check Box)	No	Yes
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		
Breast Cancer		

Health Assessment for Men

Name: ______________________ Date: ______________________

Mail: ______________________

SYMPTOMS (Please Check Box)

	Never	Mild	Moderate	Severe
1) Fatigue	☐	☐	☐	☐
2) Mood Changes: Irritability Anxiety / Nervousness Depression	☐	☐	☐	☐
3) Decreased Mental Ability: Memory Loss Confusion Loss of Focus	☐	☐	☐	☐
4) Excessive Sweating	☐	☐	☐	☐
5) Weight Gain: Bloating Excessive Belly Fat Inability to Lose Weight	☐	☐	☐	☐
6) Decreased Sex Drive: No Morning Erections	☐	☐	☐	☐
7) Sleep Problems: Can't Stay Asleep Can't Fall Asleep	☐	☐	☐	☐
8) Decreased Muscle Strength	☐	☐	☐	☐
9) Hair loss / Breakage	☐	☐	☐	☐
10) Joint Pain / Muscle Aches	☐	☐	☐	☐

FAMILY HISTORY (Please Check Box)

	No	Yes
Heart Disease	☐	☐
Diabetes	☐	☐
Osteoporosis	☐	☐
Alzheimer's Disease	☐	☐
Prostate Cancer	☐	☐

ALLERGY IMPACT QUESTIONNAIRE

PATIENT NAME: ______________________ DOB: ____________ TODAY'S DATE: ____________

1. Do you think you suffer from allergies? Yes / No
2. Are the symptoms all year around or seasonal? Year Long / Seasonal
3. How long do your symptoms last during an allergy flare up? Less than 7 days / More than 7 days
4. What time of the day are your symptoms the worst? Morning / Afternoon / Night / All day
5. Are the symptoms worse in the spring, fall or both? Spring / Fall / Both
6. Do you have any sinus drainage issues? Yes / No If Yes, When? AM / PM / All day
7. Do you ever have watery or itchy eyes? Always / Most Time / Sometimes / Never
8. Do you cough or sneeze on a regular basis? Yes / No If Yes, When? AM / PM / All day
9. Do you have regular Upper Respiratory Infections? Yes / No If Yes, <3 or >3 per year
10. Do you think you might be allergic to animals? Yes / No
11. Have you been diagnosed with Asthma? Yes / No If yes, When ______________
12. Do you have a family history of Asthma? Yes / No
13. Have you ever been hospitalized for asthma? Yes / No

    If yes, when was the last time? ______________________
14. How long have you lived in Texas? _____ Years / _____ Months
15. How long have you lived in your current residence? _____ Years / _____ Months
16. Did you have allergies in your previous residence or state? Yes / No
17. Are you currently taking any allergy medication? Yes / No

    If yes, please list all medications including any over the counter medications. ______________
18. Are you currently taking any blood thinner medications? Yes / No

    If yes, please list: ______________________
19. Are you currently taking a beta-blocker for a heart condition? Yes / No / Unsure
20. Are you or could you be pregnant? Yes / No

ALLERGY QUALITY OF LIFE QUESTIONNAIRE

PATIENT NAME: ______________________ DOB: ______________ TODAY'S DATE: ______________

The following 16 subject symptoms and lifestyle questions are used to assess your allergy symptoms and the impact they have on your quality of life. Each one is based on a 1 to 10 scale, where 1 has very little impact and 10 equates to a severe impact that allergies have on your overall quality of life. Please rate the following:

		MILD				MODERATE				SEVERE	
1.	Watery, itchy/burning eyes	1	2	3	4	5	6	7	8	9	10
2.	Ear infections/discharge	1	2	3	4	5	6	7	8	9	10
3.	Sinus tenderness/drainage	1	2	3	4	5	6	7	8	9	10
4.	Sinus infections	1	2	3	4	5	6	7	8	9	10
5.	Throat tenderness	1	2	3	4	5	6	7	8	9	10
6.	Coughing/sneezing	1	2	3	4	5	6	7	8	9	10
7.	Headache/migraine	1	2	3	4	5	6	7	8	9	10
8.	Rash/dermatitis	1	2	3	4	5	6	7	8	9	10
9.	Respiratory infections	1	2	3	4	5	6	7	8	9	10
10.	Sleep disturbance	1	2	3	4	5	6	7	8	9	10

11. Please rate your overall medication use (over the counter & prescription) to control your allergy symptoms:

1 2 3 4 5 6 7 8 9 10

12. In the past month, rate the impact your allergies have had on social events or hobbies:

1 2 3 4 5 6 7 8 9 10

13. In the past month, rate the impact your allergies have had on your employment or school:

1 2 3 4 5 6 7 8 9 10

14. In the past month, rate the overall allergy symptoms you have experienced when you are around or in contact with animals:

1 2 3 4 5 6 7 8 9 10

15. In the past month, how would you rate your overall allergy symptoms when exposed to the outdoors:

1 2 3 4 5 6 7 8 9 10

16. In the past month, how would you rate your overall allergy symptoms when at home or when performing household work:

1 2 3 4 5 6 7 8 9 10