Dr. Laura Pickett

Dermatology
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Last Name:	First Name:
Address:	
City:	Postal Code:
Date of Birth:	Sex:
Tel. (H):	Tel. (C):
Health Card No.	Email:
Occupation:	Family Physician:
Insurance Company:	Referring Physician:

Prescribed Oral Medications:	**Non- prescribed medications:**	**Creams:**

Allergies to medication? ☐ Yes ☐ No If Yes, to what? _____

Are you on blood thinner? (Aspirin, Plavix, Coumadin, other): ☐ Yes ☐No

Female Patients (check all that apply):☐ Pregnant ☐ Nursing ☐ Planning to become pregnant? ☐ N/A

Check and health conditions you have ever had:

☐ Eczema ☐ Hepatitis(A/B/C) ☐ Crohn's/Colitis ☐ Other_____
☐ Psoriasis ☐ Anxiety/Depression ☐ Pacemaker _____
☐ Asthma ☐ Thyroid disease ☐ High Blood Pressure _____
☐ Seasonal Allergies ☐ Cancer/ What type? _____ ☐ Blood Clots _____

☐HeartAttack/Arrythmia ☐Autoimmune Disease? _____ ☐Melanoma
☐Other Skin Cancer (Basal/Squamous)

Please check off or list any family history of diseases :

☐Eczema ☐Autoimmume Disease ☐ Other _____
☐Asthma ☐Arthritis (which type?)_____ _____
☐Seasonal Allergies _____

Do any of the following concern you? Please circle all that apply

☐Wrinkles ☐Brown Spots ☐Redness ☐Facial Veins ☐Scarring ☐Rosacea

☐Enlarged Pores ☐Stretch Marks ☐Cellulite ☐Double Chin/Jowls ☐Freckles ☐Pigmentation

☐Saggy/Crepey Skin ☐Skin Tags ☐Moles ☐Capillaries ☐Acne

☐ **I have read and understand the office policies.**

Patient Signature: _____ Date: _____