The South Bend Clinic
A Lifetime of Care

DERMATOLOGY & SKIN SURGERY

RETURN PATIENT FORM

Please complete the form below:

Appointment Date: ______/______/______

Patient Name: ____ **Date of Birth:** ______/______/______

REASON FOR TODAY'S VISIT

Reason for Visit: ____

Any new problems?, if yes please explain: ____

Location: ☐ Arms ☐ Back ☐ Legs ☐ Head/neck ☐ Chest/abdomen ☐ Genitals

Symptoms: ☐ Itching ☐ Bleeding ☐ Pain ☐ Other: ______________________________

ALLERGIES TO MEDICATIONS

☐ No Known Allergies List any **NEW** *Allergies and/or intolerances to medications & indicate reaction*

Medication Allergy	Reaction(s)
	☐ Rash ☐ Nausea ☐ Unknown ☐ Other: ____________________
	☐ Rash ☐ Nausea ☐ Unknown ☐ Other: ____________________

MEDICATIONS/VITAMINS/SUPPLEMENTS

List any newly prescribed medications since your last visit. *☐ Not taking any medications*

Medication	Dose (strength & quantity)	Prescribing Doctor
1.		
2.		
3.		
4.		
5.		

Continue on back page if needed….

MEDICAL HISTORY

Since your last visit have you had any new surgeries or newly diagnosed skin cancers, if so please list below:

____

FAMILY HISTORY

Since your last visit has any family member(s) been diagnosed with any skin cancers? ☐ No ☐ Yes, list below:

____

SOCIAL HISTORY

Tobacco Do you use tobacco? ☐ No/Never ☐ Yes ☐ Former - How long ago? _____ Age Quit:_____

Type/Status: ☐ Current every day smoker ☐ Current some day smoker

Patient or responsible party**:** ____ **Date:** _____/______/______

(Signature)