BROWN DERMATOLOGY
BROWN PHYSICIANS, INC.

PEDIATRIC DERMATOLOGY NEW PATIENT QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____

PREFERRED NAME OF CHILD: _____
CHILD'S PEDIATRICIAN/PRIMARY CARE PROVIDER: _____
PEDIATRICIAN/PCP ADDRESS: _____
PHARMACY: _____
EMAIL:_____

WHO REFERRED YOU TO OUR PRACTICE FOR EVALUATION?

PEDIATRICIAN	***DERMATOLOGIST (NAME: _____)***	***SELF***	***HOSPITAL***
PHONE	***INTERNET***	***OTHER _____***	

HISTORY

Does your child have any past or present medical problems? (List)_____
Any past surgeries? (Please list) _____
Any past hospitalizations? (Please describe) _____

FAMILY HISTORY

Please indicate ✔ if any family members have had the following problems?
GF=GRANDFATHER, GM=GRANDMOTHER, BRO=BROTHER, SIS=SISTER, OTHER=AUNTS, UNCLES, COUSINS

	MOM	*DAD*	*SIS*	*BRO*	*GF*	*GM*	*OTHER*
ECZEMA							
ASTHMA							
HAY FEVER							
PSORIASIS							
SKIN CANCER							
MELANOMA							
ABNORMAL MOLE							

SOCIAL HISTORY

Please list siblings and ages:

_____

_____

Child's primary caretaker (circle) Mom Dad Both Grandparent Other _____

Grade in school (circle) PreK 1 2 3 4 5 6 7 8 9 10 11 12 College

Pets at home? _____ ***Day Care*** ☐ YES ☐ NO

Please flip over ----------→

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PATIENT NAME: _____

DATE OF BIRTH: _____

SUN HISTORY

Please describe patient's skin as closely as you can:

☐ *Burns, freckles easily never tans*	☐ *Burns, occasionally tans readily*
☐ *Burns, easily tans poorly*	☐ *Never burns, tans well*

Sunscreen Use

☐ *Never*	☐ *Usually before spring or summer outdoor activity*
☐ *Occasionally*	☐ *Year-round*
☐ *Sometimes before spring or summertime outdoor activity*	☐ *Always before spring or summertime outdoor activity*

Sunscreen type and SPF: _____ ***Tanning bed use:*** ☐ ***YES*** ☐ ***NO***

CURRENT MEDICATIONS(List): _____

MEDICATIONS ALLERGIES OR SERIOUS FOOD ALLERGIES: _____

_____

REVIEW OF SYSTEMS

Please indicate whether your child has experienced any of these symptoms by checking YES (Y) or NO (N) for each

	Yes	No		Yes	No
Growth problems			*Heart Problem*		
Eye Problem			*Joint Pain*		
Ear, nose, throat			*Muscle or bone problem*		
Seizure			*Fever*		
Headaches			*Swollen glands lymph nodes*		
Jaundice or hepatitis			*Learning disorder/school problem*		
Weight Change			*Poor Appetite*		
Wheezing shortness of breath			*Urinary Problems*		

Child's interests, hobbies, activities: _____

Is there anything else you would like us to know? _____

Signature of the person filing out form _____ ***Date:*** _____

Relation to Patient _____

MEDICAL TEAM USE ONLY

REVIEWED BY: