MEDICAL AESTHETICS OF MUSKOKA

Dermatology Patient Health History Form

Please complete both pages. 1/2 Pages

This form is to assist MAOM in triaging your skin problem AFTER WE HAVE RECEIVED A REFFERAL from your Primary Care Provider (PCP). Completing and returning this form does not mean that you are under the care of Dr. Kents. Medical care is assumed at the time of your initial assessment. Forms received from patients who have not already been referred by their PCP will be shredded/ deleted. Email the completed form to scheduling@maom.ca, or drop it off at the clinic.

THIS FORM MUST BE COMPLETED IN FULL & RETURNED TO MAOM PRIOR TO THE SCHEDULING OF YOUR APPOINTMENT.

Please print legibly.

Date (dd/mm/yyyy):	Email:
Name:	Birth date (dd/mm/yyyy):
Phone (home):	Phone (mobile):
Health Card Number:	Health Card Version Code (2 letters):

What is the reason for your referral to Dr. Kents:

☐ Skin check (screening)	☐ Rash	☐ Itchy skin (no rash)	☐ Acne
☐ Pigmentation issues	☐ Psoriasis	☐ Eczema/Dermatitis	☐ Rosacea
☐ Nail issues	☐ Hair loss	☐ Boils	☐ Wart Treatment
☐ Specific lesion to assess (lumps, bumps, spots)	☐ Other (specify):		

Provide the following details regarding your skin problem:

1) What does it look like (flat patches, bumps, blisters, colour of lesions, flaky, etc.)	
2) When did it start	3) Where on your body did it start
4) Where did it spread to next (in what order)	
5) List any areas of the body that are NOT involved (mouth, private area, scalp, etc.)	
6) Does it come and go, or is it continuous	7) Is it changing, or is it the same
8) List anything that makes it better	
9) List anything that makes it worse (especially sun exposure, seasons, heat/cold, exercise, pregnancy)	
10) How severe is it (eg. does it keep you up at night? is it causing distress? does it affect your daily functioning?)	
11) Is it ☐ itchy ☐ painful ☐ bleeding ☐ blistering ☐ discharging	
☐ other features (specify)	
12) Any ☐ fever ☐ chills ☐ achy muscles, ☐ achy joints, ☐ none	
13) Any changes to your hair (head and body) or nails? ☐ no ☐ yes (specify)	
14) Anyone else close to you have the same symptoms? ☐ no ☐ yes (specify)	
15) Any changes in medications/diet/skin care products around the time it started? If so, list them below	

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List ANY known SKIN conditions (past and present), INCLUDING cancers/ melanomas:	List ALL medications/creams tried for you CURRENT skin problem:

List ALL MEDICAL CONDITIONS (past and present):	List ALL medications you CURRENTLY USE for ANY MEDICAL CONDITION (names only, no dosages required):

List ALL skin care, hair care and laundry products you use (NOT required if coming for skin check or specific lesion):

Are you on a blood thinner (Aspirin, Plavix, Coumadin, other): ☐ no ☐ yes (specify)

List any ALLERGIES to medications:

Do you have a FAMILY HISTORY of any of the following (check all appropriate boxes)?

☐ Melanoma	☐ Non-melanoma skin cancer	☐ Psoriasis	☐ Diabetes	☐ Thyroid disease
☐ Bowel disease (Crohn's, colitis, celiac)	☐ Autoimmune disorders	☐ Arthritis	☐ Eczema	☐ Blood clots

Review the following clinic policy forms and consents (available on our website www.maom.ca, under the Dermatology tab) and initial below as appropriate. Copies of these forms can also be sent to you by email or regular mail upon request. Your consent to the use of photographs for documenting medical conditions, illustrating medical procedures and the demonstration of treatment outcomes is required.

I have read, understand, and accept the MAOM Clinic Policies (initials required)	
I have read, understand, and accept the MAOM Virtual Care Policies (initials required)	
I have read, understand, and accept the MAOM Photography Consent Policy (initials required)	
I have read, understand, and accept the MAOM Email Consent Policy (initials required)	

Please provide any further information below that you may find relevant or helpful to assist us with understanding your skin problem (attach another page if needed):