DERMATOLOGY-CHICAGO CLINICAL INFORMATION SHEET

Office Account Number:___________________

Last Name: ____________________________ First Name____________________________

Date of Birth: __________________________

Medications: (name only don't need dosage)

Drug Allergies:

Preferred Pharmacy:____

Location of Phamacy:____

Are you a smoker?____________________

If you formerly smoked, when did you quit?__________________________

How did you hear about / referred to office____

Google__________________ Zoc Doc___________________ Patient referral________________

Physician Referral: (name of physican) ____

General reason for visit:____

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