LAKE SHORE DERMATOLOGY

Kavitha Gandhi, M.D.

T 847.680.7100
F 847.775.0704

NEW PATIENT INFORMATION

First Name ____________________ Middle Name ___________________ Last Name _________________________

Sex F M Social Security # _____________________ Date of Birth _____________ Marital Status ____

(These questions suggested by USGovt for electronic health records:) Nationality ______________ Language________ Race __________

Street Address ___________________________ City _________________ State ______ Zip Code ________

Home Tel # ____________________ Work Tel # ____________________ Mobile Tel# ______________________

Which is the single best number to contact you and/or leave a message (appointment reminder, results, etc.)? Home Work Mobile

Email Address ____

Employer ______________________ Work Address ______________________ Occupation ______________________

FINANCIALLY RESPONSIBLE PARTY (IF OTHER THAN YOU)

Name ________________________ Relation to patient ______________ Sex F M

Date of Birth __________________ Social Security #___________________

Mailing Address ____

Home Tel # ____________________ Work Tel # ____________________ Mobile Tel #_________________

Employer ______________________ Work Address ____

WHO REFERRED YOU? Name: ____

(Circle all that apply) Family Friend Physician Insurance Directory Online Other________________

YOUR MEDICAL DOCTOR: INTERNIST / PRIMARY CARE PHYSICIAN

Name ______________________ Tel # ________________ Did he/she refer you for a consultation? Yes No

PHARMACY INFORMATION

Name ______________________ City __________________ Tel # ____

EMERGENCY CONTACT

Relation to self ___________________________

Name ____________________________ Home Tel # ______________________ Mobile Tel # ______________________

Please present insurance card to the receptionist so copies may be made.

I CERTIFY THAT THE ABOVE INFORMATION IS ACCURATE. I ALSO UNDERSTAND THAT SHOULD THERE BE ANY CHANGES TO THIS INFORMATION, THAT IT IS MY RESPONSIBILITY TO UPDATE THIS INFORMATION. I AUTHORIZE THE PAYMENT OF MEDICAL BENEFITS FOR MYSELF (OR MY DEPENDENTS) DIRECTLY TO KAVITHA GANDHI, MD FOR PROFESSIONAL MEDICAL SERVICES.

_______________________________________ _________________________
PATIENT/GUARDIAN SIGNATURE DAT

LAKE SHORE DERMATOLOGY

Kavitha Gandhi, M.D.

T 847.680.7100
F 847.775.0704

MEDICAL HISTORY QUESTIONAIRE

PATIENT NAME ______________________________ DATE ______________________________

REASON FOR TODAY'S VISIT: ____

____

List ALL MEDICATIONS and SUPPLEMENTS you are currently taking (including non prescription medications and birth control):____

ARE YOU ALLERGIC TO ANY MEDICATIONS? ❑ YES ❑ NO IF YES, LIST ____________________

HAVE YOU EVER HAD A REACTION TO NOVOCAINE, LIDOCAINE, BANDAGES, LATEX, OR TOPICAL ANTIBIOTICS (NEOSPORIN, POLYSPORIN, BACITRACIN)? ❑ YES ❑ NO IF YES, LIST ____________________

PAST MEDICAL HISTORY (HAVE YOU EVER HAD?)

- ❑ ARTHRITIS
- ❑ CANCER (TYPE: ____________)
- ❑ CATARACTS
- ❑ DEFIBRILLATOR/PACEMAKER
- ❑ DIABETES
- ❑ EMPHYSEMA/COPD
- ❑ GLAUCOMA
- ❑ HEART ATTACK
- ❑ HEART VALVE DISEASE/REPLACEMENT
- ❑ HEPATITIS
- ❑ HIV
- ❑ HIGH CHOLESTEROL
- ❑ HIGH BLOOD PRESSURE
- ❑ IRREGULAR HEARTBEAT
- ❑ JOINT REPLACEMENT
- ❑ KIDNEY DISEASE
- ❑ LIVER DISEASE
- ❑ LUPUS
- ❑ OTHER CONNECTIVE TISSUE DISEASE
- ❑ SEIZURE DISORDER
- ❑ STOMACH/INTESTINAL DISEASE
- ❑ OTHER ____________________

____

____

DERMATOLOGIC PERSONAL AND FAMILY HISTORY (HAVE YOU OR A MEMBER OR YOUR FAMILY EVER HAD)?

	YOU	FAMILY MEMBER (WHO)
ADOPTED	❑	
ABNORMAL MOLES (DYSPLASTIC NEVI)	❑	❑ __________
ACTINIC KERATOSIS	❑	❑ __________
ALLERGIES/HAYFEVER	❑	❑ __________
ASTHMA	❑	❑ __________
ATOPIC DERMATITIS (ECZEMA)	❑	❑ __________
BASAL CELL CARCINOMA	❑	❑ __________
KELOIDS	❑	❑ __________
MELANOMA	❑	❑ __________
PSORIASIS	❑	❑ __________
SKIN CANCER (TYPE UNKNOWN)	❑	❑ __________
SQUAMOUS CELL CARCINOMA	❑	❑ __________
THYROID DISEASE	❑	❑ __________

SOCIAL HISTORY

Do you drink alcohol?	❑ YES # drinks/day ____	❑ NO
Do you smoke?	❑ YES #packs/day ____	❑ NO
Do you use recreational drugs?	❑ YES	❑ NO
Do you have or have you been exposed to any infectious diseases?	❑ YES	❑ NO

Please explain: ______________________________________

What are your hobbies? ______________________________

SKIN

When exposed to the sun do you?

❑ TAN ❑ TAN & BURN ❑ BURN

Do you use sunscreen?	❑ YES	❑ NO
Have you ever laid out in the sun to tan?	❑ YES	❑ NO
Do you or have you ever gone to tanning salons?	❑ YES	❑ NO
Have you had any bad or blistering sunburns?	❑ YES	❑ NO

SURGICAL HISTORY

SURGERIES YOU HAVE HAD ____

DO YOU HAVE A HEART PROBLEM OR ARTIFICIAL JOINT REQUIRING ANTIBIOTIC TREATMENT BEFORE PROCEDURES? ❑ YES ❑ NO

LAKE SHORE DERMATOLOGY

Kavitha Gandhi, M.D.

T 847.680.7100
F 847.775.0704

PATIENT NAME (PLEASE PRINT) ____

REVIEW OF SYSTEMS: CHECK ANY CURRENT PROBLEMS AND EXPLAIN

Constitutional		
Feeling tired or poorly	❑ Yes	❑ No
Fever (as symptom)	❑ Yes	❑ No
Chills (as symptom	❑ Yes	❑ No
Recent weight loss (lbs ________)	❑ Yes	❑ No
Recent weight gain (lbs ________)	❑ Yes	❑ No
Ophthalmology		
Blurry vision	❑ Yes	❑ No
Change in vision	❑ Yes	❑ No
Decreased vision	❑ Yes	❑ No
Eye irritation	❑ Yes	❑ No
Ear, Nose, Throat		
Nasal congestion	❑ Yes	❑ No
Post-nasal drip	❑ Yes	❑ No
Sore throat	❑ Yes	❑ No
Earache	❑ Yes	❑ No
Ringing of ears	❑ Yes	❑ No
Difficulty swallowing	❑ Yes	❑ No
Respiratory		
Cough	❑ Yes	❑ No
Shortness of breath	❑ Yes	❑ No
Cardiovascular		
Palpitations	❑ Yes	❑ No
Chest pain	❑ Yes	❑ No
Leg swelling	❑ Yes	❑ No
Varicose veins	❑ Yes	❑ No

Gastrointestinal		
Decreased appetite	❑ Yes	❑ No
Abdominal pain	❑ Yes	❑ No
Nausea	❑ Yes	❑ No
Vomiting	❑ Yes	❑ No
Diarrhea	❑ Yes	❑ No
Constipation	❑ Yes	❑ No
Blood in stool	❑ Yes	❑ No
Urinary		
Pain during urination	❑ Yes	❑ No
Increased frequency of urination	❑ Yes	❑ No
Blood in urine	❑ Yes	❑ No
Musculoskeletal		
Muscle pain	❑ Yes	❑ No
Decrease in muscle strength	❑ Yes	❑ No
Joint pain	❑ Yes	❑ No
Joint stiffness	❑ Yes	❑ No
Neuro		
Headaches	❑ Yes	❑ No
Dizziness	❑ Yes	❑ No
Numbness	❑ Yes	❑ No
Tingling	❑ Yes	❑ No

Psychiatric		
Depression	❑ Yes	❑ No
Anxiety	❑ Yes	❑ No
Endocrine		
Excessive thirst	❑ Yes	❑ No
Heat/cold intolerance	❑ Yes	❑ No
Excessive sweating	❑ Yes	❑ No
Heme		
Easy bruising	❑ Yes	❑ No
Night sweats	❑ Yes	❑ No
Fatigue	❑ Yes	❑ No
Swollen glands	❑ Yes	❑ No
Allergic/Immunologic		
Hives	❑ Yes	❑ No
Gynecologic (women only)		
Pregnant	❑ Yes	❑ No
Trying to conceive	❑ Yes	❑ No
Difficulty conceiving	❑ Yes	❑ No
Irregular periods	❑ Yes	❑ No
Skin (see above cc)		

Other ______________________________
____
____
____

PATIENT SIGNATURE ____

PARENT OR GUARDIAN SIGNATURE ____
DATE ____

PHYSICIAN SIGNATURE: ______________________________________ DATE: ____________________