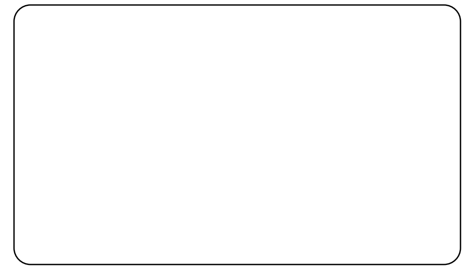
APDerm®
BOSTON DERMATOLOGY
& LASER CENTER



New Patient Form

30 Lancaster Street Boston, MA 02114
Tel: 617-722-4100 | Fax: 617-227-1134 | www.bostondermandlaser.com

Patient Information

Name

First *Last* *M.I.*

Social Security #	**Sex**	**DOB** ____/____/______ *MM* *DD* *YYYY*

Address

Street *City* *State* *ZIP*

Cell Phone	**Home Phone**
Work Phone	**Email**
Employer	**Occupation**
Marital Status ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	**Spouse's Name**

Primary Care Physician

Name *Phone Number*

Preferred Pharmacy

Name *Street* *City* *State* *ZIP*

Emergency Contact

Name *Relation to Patient* *Phone Number*

Reason for Visit

Current Medications	Allergies
Name *Dose*	
Name *Dose*	
Name *Dose*	
Name *Dose*	
Name *Dose*	
Name *Dose*	
Name *Dose*	
Name *Dose*	
Name *Dose*	

PLEASE SEE OTHER SIDE →

Skin

Do you have any of the following?

- ☐ Abnormal/Changing Moles
- ☐ Acne
- ☐ Boils
- ☐ Bleed Easily
- ☐ Cold Sores
- ☐ Dry/Sensitive Skin
- ☐ Eczema
- ☐ Hives
- ☐ Itching
- ☐ Non-healing Sores
- ☐ Psoriasis
- ☐ Rash
- ☐ Rosacea
- ☐ Scars
- ☐ Warts
- ☐ Other ___________________

Details

When you are exposed to the sun do you:
☐ Tan Only ☐ Tan and Burn ☐ Burn Only

Have you ever used a tanning booth? ☐ Yes ☐ No
If yes, do you currently? ☐ Yes ☐ No

Do you wear sunscreen? ☐ Yes ☐ No
If yes, what SPF?

Have you ever had skin cancer?
☐ Yes ☐ No ☐ Don't Know

If yes, what type(s), where, and when?

____
Type(s) *Location(s)* *Year(s)*

____
Type(s) *Location(s)* *Year(s)*

Personal Medical History

Have you ever had any of the following?

- ☐ Alcoholism
- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Asthma
- ☐ AIDS/HIV
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Bowel Disorder
- ☐ Cancer
- ☐ Diabetes
- ☐ Depression
- ☐ Eating Disorder
- ☐ Epilepsy
- ☐ Heart Disease
- ☐ Heart Problems
- ☐ Hepatitis (A, B, or C)
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Infectious Disease
- ☐ Joint Disorder
- ☐ Kidney Disorder
- ☐ Liver Disorder
- ☐ Lung Disease
- ☐ Lupus
- ☐ Measles
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Stomach Ulcer
- ☐ Substance Abuse
- ☐ Thyroid Disorder
- ☐ Tuberculosis

Details

Lifestyle Factors

Smoking Tobacco Status

- ☐ Current Every Day Smoker
- ☐ Current Some Day Smoker
- ☐ Former Smoker
- ☐ Never Smoked

Smokeless Tobacco Status

- ☐ Current User
- ☐ Former User
- ☐ Never Used

Do you drink alcohol? ☐ Yes ☐ No

If yes, how much per week?

Women Only

Are you currently pregnant? ☐ Yes ☐ No

If yes, how many weeks?

Are you trying to get pregnant? ☐ Yes ☐ No

Are you breastfeeding? ☐ Yes ☐ No

Surgical History

Surgery	*Date*

Family History

Has anyone in your family ever had any of the following?	**If yes, who?**
☐ Abnormal Moles	____________________
☐ Acne	____________________
☐ Asthma	____________________
☐ Basal Cell Carcinoma	____________________
☐ Cancer	____________________
☐ Diabetes	____________________
☐ Eczema	____________________
☐ Hair Loss	____________________
☐ Melanoma	____________________
☐ Psoriasis	____________________
☐ Skin Cancer	____________________
☐ Squamous Cell Carcinoma	____________________

I consent to receive text messages or emails regarding schedule updates, offers and events. I am aware I have the ability to opt-out at any time by calling the office. I understand Boston Dermatology and Laser Center reserves the right to charge a fee for any scheduled visits that are cancelled with less than 24 hours notice or are missed without notice (no show).

____ Signature of Patient (or Guardian if Minor)

____________________ Date