Dr. C.L. Freeman MD, CCFP, Dip.Derm, MSc

Family Medicine, practising in dermatology

Date _____

Name _____ Birth date (month/day/year)_____

Address_____

City_____Postal Code _____

Phone (Home) _____ (Work) _____

(Can we contact you at this number?_____)

Other contacts (email, fax, cell phone, alt number we can leave a message) _____

Family Doctor _____ Referring Doctor_____

Reason for your office visit today: _____Are you or could you be pregnant? _____

Have you seen Drs. Freeman/Gooderham/Singh (please circle) in the past? _____ When?_____

Reason for past appointment? _____

Please list **any** known **SKIN conditions**: (past and present)
INCLUDING CANCERS OR MELANOMAS(s):

_____

_____

_____

_____

Medications/ creams
tried for your **current** skin problem

_____

_____

_____

_____

Please list **all medical conditions**:(past and present)

_____

_____

_____

_____

_____

ALL medications you currently use for any medical condition
If providing a list please give to reception

_____

_____

_____

_____

Are you on a blood thinner? (Aspirin, Plavix, Coumadin, other): Yes No

Please list any **allergies** to medications: _____

What pharmacy do you use? _____Location of pharmacy?_____

Family History (please circle any conditions present in bloodline family members and indicate who that person is):

Melanoma Non-melanoma skin cancer Other Cancer Thyroid Disease Stroke Blood Clots

Psoriasis Autoimmune Disorders Diabetes Bowel Disease Arthritis Eczema

I have read and understand 'Office Policies' for Dermatology: _____

(Please sign)