

Westside Dermatology, LLC
1410-B John B. White, Sr.
Spartanburg, SC 29306
PH. (864) 574-0017/Fax. - 6088

Peter J. Neidenbach, M.D.
Thomas C. Hokanson, PA-C
Allyson N. Cook, PA-C

Chart # _____
Date: _____

Patient's Name: _____

Male [] Female []

Address: _____
Street
City State ZIP

Phone #: _____

Work #: _____

Date of Birth: ___/___/___ Age: ___ Social Security #: ___-___-___

Occupation: _____ Place of Employment: _____

Spouse's Name: _____ Spouse's Employer: _____

Family Physician: _____ Referred by: _____

Single [] Married [] Divorced [] Widowed []

List all prescription and non-prescription medications you are now taking:

Please circle anything that applies to you:

- | | | |
|----------------------------|-----------------------------------|--------------------------------------|
| Hepatitis or Liver Disease | Fever Blisters (anywhere on body) | Bleeding Disorder or Blood Disease |
| Epilepsy or Nerve Disease | Blood Transfusion | Lung Disease |
| HIV Infection | Stomach or Intestinal Disease | Heart Disease/Artificial Heart Valve |
| Thyroid or Hormone Disease | Blood Vessel Disease | Arthritis or Muscle Disease |
| Diabetes | High blood Pressure | Kidney Disease |
| Major Surgery | Large Scars or Keloids | Joint Replacement |

If you have any allergies, please list: _____

Please answer the following:

- Do you smoke? _____ YES _____ NO
- Are you pregnant? _____ YES _____ NO
- Do you have a heart pacemaker? _____ YES _____ NO
- Do you faint easily or bleed freely? _____ YES _____ NO
- Do you take antibiotics before dental work? _____ YES _____ NO
- Have you ever had a skin cancer? _____ YES _____ NO
- Has a family member ever had skin cancer? _____ YES _____ NO
- Have you ever been allergic to or had an unusual reaction to a local anesthetic (i.e. Novocain, adrenalin, or xylocaine)? _____ YES _____ NO
- Do you take aspirin, anti-inflammatory medications, or blood thinners? _____ YES _____ NO

What is your skin problem? _____
How long have you had it? _____
Where is it located? _____
What have you used? _____
What skin problems & treatments have you had before? _____