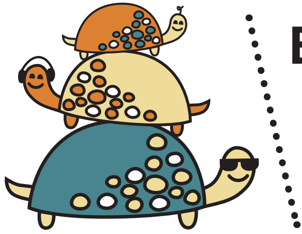

Burkhart
Pediatric &
Adolescent
Dermatology

(919) 476-1118 | (855) 878-6037
135 Parkway Office Court - Suite 201
Cary, NC 27518
info@burkhartpediatricdermatology.com
www.burkhartpediatricdermatology.com

Medical History Form

Date: ____________

Chart #: __________

Patient's Legal Name

First: ______________________________ MI: _____ Last: ____

Patient's Chosen Name: ______________________________________ Date of Birth: _________________

Reason for Today's Visit: ____

Location of the problem: ____

Length of time present: ____

Things that make it better: ____

Things that make it worse: ____

Prior treatment: ____

Previous biopsy, labs or tests: ____

Other information: ____

Past Medical History:

Health Issues: ____

Allergies (medications, food, and others): ____

Previous Hospitalizations: ____

Previous Surgeries: ____

Current Medications: ____

____

Other information: ____

Any history of health or medical problems in a close biological relative? ◯ No ◯ Yes

If Yes, please specify ____

Continued

Burkhart Pediatric & Adolescent Dermatology

Medical History Form - page 2

Does anyone in the home smoke? ◯ No ◯ Yes

Please check the box if your child has any of the following problems:

- ◯ Blood (anemia, leukemia, etc.)
- ◯ Brain or Neurologic
- ◯ Diabetes
- ◯ Ear, Nose, Throat
- ◯ Eyes or Vision
- ◯ Hearing
- ◯ Heart
- ◯ Joint or bones
- ◯ Kidneys
- ◯ Lungs or Breathing
- ◯ Mental or Behavioral Health
- ◯ Muscle or Movement
- ◯ Other Hormone Problems
- ◯ Stomach or Intestines
- ◯ Thyroid

Please provide any additional information you would like us to know about your child: ______________

____

____

Referral Information

If your child was referred by another provider, please provide contact information:

Provider Name: ____

Practice Name: ____

If your child was referred by another patient or friend, please provide contact information so we can say thank you.

Name: ____

Contact Information: ____