PATIENT QUESTIONNAIRE

NAME:	E-MAIL:	
First, Last		Granting permission to provide educational information & promotions
PHONE (Best number):		OCCUPATION:
HEALTH PROBLEMS/MEDICAL HISTORY:		
MEDICATIONS:		DRUG ALLEGIES:
PHARMACY FAX#:		PREGNANT: Yes No
DRUG PLAN: Work/Private ODB/ T	rillium	ng Account
MAIN REASON FOR CONSULT?		
WHERE IS AREA OF CONCERN?		
HOW LONG HAVE YOU HAD THE PROBLEM?		
HAVE YOU HAD THIS ISSUE BEFORE?		
ANY TREATMENTS TO DATE (E.G. RX, CREAM	MS, ETC)?	
IF YES, DID THEY HELP OR WORSEN?		
ANY OTHER SYMPTOMS (e.g. itch, burn, pain, etc. & how severe)?		
DO YOU HAVE A HISTORY OF SKIN PROBLEM	MS (E.G. ECZEMA, PSORIA	SIS, SKIN CANCER)?
☐ I hereby give consent to my dermatol	logist for virtual visit and	electronic communication.
*** Please complete questionnaire and e	mail to econsult@toront	odermatologycentre com

along with a picture of your OHIP (healthcard) and 3-4 photos of the area of concern.

TORONTO DERMATOLOGY CENTRE

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