CERTIFIED DERMATOLOGY PATIENT INTAKE FORM

01/2020

PATIENT'S NAME: _____ Today's Date: _____/_____/_____

Date of Birth: ____/____/_____ (mm/dd/yyyy) Phone: _____-_____- _____

Gender: ☐Male ☐Female	Language: ☐English ☐Spanish ☐Other
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐Widowed ☐Separated	
Race: ☐White ☐Black or African American. ☐American Indian or Alaska-Native ☐Asian ☐Other	
Ethnicity: ☐Hispanic/Latino ☐Non Hispanic/Latino	

PATIENT EMAIL: _____

PRIMARY CARE PHYSICIANS INFORMATION:

Name:_____

Phone #: _____ Fax #: _____

IS YOUR REFERRING PHYSICIAN THE SAME AS YOUR PRIMARY CARE PHYSICIAN? □ YES OR □ NO

PHARMACY INFORMATION: Name: _____ Street_____

City _____State: _____ Zip Code _____

REASON FOR YOUR VISIT TODAY

_____

_____

PAST MEDICAL HISTORY:

Please **check** any of the following medical conditions that you currently have:

☐ Anxiety	☐BPH (benign enlarged prostate)	☐COPD	☐End Stage Renal Disease	☐Hypertension	☐Hypothyroidism	☐Seizures
☐ Arthritis	☐Bone Marrow Transplant	☐Coronary Artery Disease	☐Gerd	☐HIV/Aids	☐Leukemia	☐Stroke
☐Asthma	☐Breast Cancer	☐Depression	☐Hearing Loss	☐Hypercholesteralemia (High Cholesterol)	☐Prostate Cancer	☐Other
☐Atrial Fibrilation (irregular heartbeat)	☐Colon Cancer	☐Diabetes	☐Hepatitis	☐Hyperthyroidism	☐Radiation Treatment	☐None

IMMUNIZATIONS:

Have you been vaccinated for any of the following:

☐Influenza	☐Pneumonia	☐Neither
Date Vaccinated:	Date Vaccinated	

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SURGICAL HISTORY:
Please list any surgeries you have had and when.

_____

_____

SKIN DISEASE HISTORY
Please check if you have had any of the following skin conditions:

☐Acne	☐Hay Fever/Allergies	☐Dry Skin
☐Actinic Keratosis	☐Melanoma	☐Eczema
☐Basal Cell Carcinoma	☐Precancerous Moles	☐Squamous Cell Skin Cancer
☐Poison Ivy	☐Psoriasis	☐Other
☐Flaky or Itchy Scalp	☐Blistering Sunburn	☐None

Do you wear Sunscreen? □ YES or □ NO **Do you tan in tanning salon?** □ YES or □ NO

If yes, what SPF? _____

Is there a Family History of Melanoma? ☐Yes ☐ No If YES, which relative:

☐Mother	**☐Father**	**☐Sister**	**☐Brother**	**☐Uncle**	**☐Nephew**
☐Son	**☐Daughter**	**☐Niece**	**☐Grandmother**	**☐Grandfather**	**☐none**

MEDICATIONS: (Please list- if you have a list with you, enter here and give to nurse in exam room)

_____

_____

_____

ALLERGIES TO MEDICATIONS: □YES IF YES, LIST HERE BELOW □ NO Known Drug Allergies

_____

_____

SOCIAL HISTORY:
FEMALES ONLY: Last menstrual period (LMP): _____ Menopausal: □ Yes or □ No

SMOKING HISTORY: □ Current smoker □ Former smoker □ Never Smoked □ Unknown

Patient is NOT their own POA (Power of Attorney) □ YES □ NO

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Please check Yes or No if you have any of the following:

Allergy to Adhesive	☐yes	☐no	
Allergy to Latex	☐yes	☐no	
Allergy to Lidocaine	☐yes	☐no	
Allergy to topical antibiotic cream	☐yes	☐no	
Artificial Heart Valve	☐yes	☐no	
Artificial Joints within past 2 years	☐yes	☐no	
Blood Thinners	☐yes	☐no	
Defibrillator	☐yes	☐no	
MRSA	☐yes	☐no	
Immunosuppressant	☐yes	☐no	
Pacemaker	☐yes	☐no	
Pregnant or planning a pregnancy	☐yes	☐no	☐n/a
Premedication prior to procedure	☐yes	☐no	
Problems with Bleeding	☐yes	☐no	
Rapid Heartbeat with Epinephrine	☐yes	☐no	
West Africa Contact or travel	☐yes	☐no	

COSMETIC SERVICES:

WE NOW OFFER COSMETIC DERMATOLOGY SERVICES, DO YOU WANT TO LEARN MORE ABOUT COSMETIC TREATMENTS?

Please check any of the following services we offer for more information:

□ Fine lines	□ Excessive Fat Deposits
□ Weight Loss	□ Wrinkles
□ Acne scarring	□ Hair Loss
□ Loss of fullness in face	□ Loss of fullness in lips
□ BOTOX and other fillers	□ Cool Sculpting
□ Eyes (Eye lids, swelling)	□ Other Services or Concerns

Please list any areas of concern or questions for cosmetic procedures:

_____

_____

Patient's Signature _____ Date ____/_____/_____