



PATIENT INTAKE FORM

Name _____ Date of Birth _____

Account Number _____ Email Address _____

PAST MEDICAL HISTORY: (Please circle all that apply)

NONE

- | | | |
|------------------------|-------------------------|-------------------------------|
| Anxiety | Coronary Artery Disease | High Cholesterol |
| Arthritis | Depression | Thyroid Problem - High or Low |
| Asthma | Diabetes | Lung Cancer |
| Atrial Fibrillation | End Stage Renal Disease | Lymphoma/Leukemia |
| Bone Marrow Transplant | Hearing Loss | Prostate Cancer |
| Breast Cancer | Hepatitis | Radiation Treatments |
| Colon Cancer | High Blood Pressure | Seizures |
| COPD | HIV/AIDS | Stroke |

Other _____

PAST SURGICAL HISTORY: (Please circle all that apply)

NONE

- | | |
|------------------------------|---|
| Appendix Removed | Joint Replacement, Hip - Right or Left |
| Biological Valve Replacement | Joint Replacement, Knee - Right or Left |
| Breast Implants | Kidney Removed |
| Colectomy | Kidney Transplant |
| Coronary Artery Bypass | Mechanical Valve Replacement |
| Mastectomy - Right or Left | Ovaries Removed - Reason _____ |
| Gallbladder Removed | Prostate Removed - Reason _____ |
| Heart Transplant | Testicles Removed - Reason _____ |

Hysterectomy - Reason _____

Other _____



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PAST SKIN DISEASE HISTORY: (Please circle all that apply)

NONE

Acne

Dry Skin

Poison Ivy

Actinic Keratosis

Eczema

Precancerous Moles

Asthma

Flaking or Itching Scalp

Psoriasis

Basal Cell Skin Cancer

Hay Fever/Allergies

Squamous Cell Skin Cancer

Blistering Sunburns

Melanoma

Other _____

Medications: (Please list current medications with dosage & frequency, including over the counter)

Allergies: (Please enter all allergies)

Social History: (Please circle all that apply)

Cigarette Smoking:

Currently smokes

Has smoked in the past

Never smoked

Former smoker



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Do you have a family history of: (List first degree relatives)

Melanoma _____ Hypertension _____

Breast cancer _____ Diabetes _____

Race: _____ Ethnic group: _____

Preferred pharmacy: _____ Zip Code/Location: _____

Do you have an advance directive? _____ Or living will? _____

In the last 12 months, have you had a flu shot? When: _____

Or pneumonia shot? When: _____

Review of Systems: (Please circle all that apply)

- | | | |
|----------------|------------------------|--------------------------------|
| Anxiety | Fever or Chills | Problems with scarring |
| Abdominal pain | Hay Fever | Rash |
| Bloody stool | Headaches | Seizures |
| Bloody urine | Immunosuppression | Shortness of breath |
| Blurry vision | Joint aches | Sore throat |
| Chest Pain | Night Sweats | Thyroid problems |
| Cough | Problems with bleeding | Unintentional weight gain/loss |
| Depression | Problems with healing | Wheezing |

How did you hear about us? (Please circle all that apply)

- | | |
|--------------------|-----------------------------|
| Facebook/Instagram | Patient Referral |
| Google Search | From a Friend/Family Member |
| Other _____ | |

Yes, I'd like emails from Dermatology & Skin Surgery Clinic with skin care tips and other general messages from the clinic. By agreeing, you're giving us permission to share your name and email only with a local third-party marketing group that we work closely with.