Patient Intake/History Form

Name_____ Today's Date_____/_____/_____
First Middle Last
Address_____
Street Apt # City State Zip Code

Home Phone Number: ( )_____ Mobile Phone Number: ( )_____

Email Address:_____ SSN: _____

□ Single □ Married □ Divorced □ Widowed

Age:_____ Sex: □ Male □ Female Date of Birth:_____/_____/_____

Profession:_____ Business Telephone Number:( )_____

MISSED APPOINTMENTS:
In order to provide the best possible service and availability to all our patients, we request that you call to cancel any appointments at least 24 hours prior. Please call us as early as possible if you know you will need to reschedule your appointment. _____

Who may we thank for referring you to us? _____
Reason for evaluation:

_____

Prior skin treatments include:

_____

Date of last procedure:

_____

Adverse effects to prior procedures □ Yes □ No If Yes please explain:_____

_____

When was your last visit to your Dermatologist?_____
Name of your Dermatologist:_____ Phone Number: ( ) _____
Female patients only:

Are you taking oral contraceptives? □ Yes □ No
Are you pregnant or trying to become pregnant? □ Yes □ No
Have you had a hysterectomy or tubal ligation? □ Yes □ No

Do you have a history of herpes simplex / cold sores / fever blisters? □ Yes □No
Do you have an artificial heart valve, joint or other prosthesis that requires you to take antibiotics when you have dental procedures? □ Yes □ No If yes, which antibiotic: _____
Are you allergic to Band-Aids, tape or adhesive? □ Yes □ No

List all medications that you are currently taking:

_____
_____

List all supplements that you are currently taking:

_____

List all allergies (food, drugs, etc.):

_____

List all surgeries:

_____
_____

Past Medical History:

(check box if you or anyone in your family has had any of the following conditions)

	Self	Date	Family
Actinic Keratosis	□	_____	□
Basal Cell Carcinoma	□	_____	□
Blistering Sun Burns	□	_____	□
Eczema	□	_____	□
Keloids / Scarring problems	□	_____	□
Melanoma (depth_____)	□	_____	□
Psoriasis	□	_____	□
Squamous Cell Carcinoma	□	_____	□
AIDS / HIV	□	_____	□
Alcoholism	□	_____	□
Alzheimer's	□	_____	□
Anemia	□	_____	□
Arthrits	□	_____	□
Asthma	□	_____	□
Bleeding Disorder	□	_____	□
Cataracts	□	_____	□
Convulsions / Seizures	□	_____	□
Diabetes	□	_____	□
COPD	□	_____	□
Emphysema	□	_____	□
Heart Trouble	□	_____	□
Hepatitis (type:_____)	□	_____	□
Hypertension	□	_____	□
Glaucoma	□	_____	□
Kidney Disease	□	_____	□
Liver Disease	□	_____	□
Lupus	□	_____	□
Mental Illness	□	_____	□
Migraines	□	_____	□
Prostate Problems	□	_____	□
Stomach or Duodenal Ulcers	□	_____	□
Stroke	□	_____	□
Tuberculosis	□	_____	□

Other: _____

Cancer (non skin) Type:_____ Date: _____ Treatment: _____

Are you having any problems with any of the following:

Weight gain: □ Yes □ No	Nose: □ Yes □ No	Urinary system: □ Yes □ No
Weight loss: □ Yes □ No	Throat: □ Yes □ No	Skin: □ Yes □ No
Change in vision: □ Yes □ No	Heart: □ Yes □ No	Psychiatric problems: □ Yes □ No
Fever: □ Yes □ No	Lungs: □ Yes □ No	Endocrine: □ Yes □ No
Eyes: □ Yes □ No	Digestive system: □ Yes □ No	Blood problems: □ Yes □ No
Ears: □ Yes □ No		

If you answered yes to any of the above please explain: _____

_____

_____

_____

I hereby acknowledge that I have read this form and I understand its contents and agree to all of the provisions contained herein.

Signature:_____ Date:_____

Witness:_____ Date:_____

Reviewed by: _____ Date:_____

Current Daily Skincare Regimen

Please list any products that you are currently using and how often you use them to maintain healthy skin:

Cleanser(s)_____

Toner(s)_____

Treatment(s)_____

Serum(s)_____

Moisturizer(s)_____

Sunscreen(s)_____

Additional information:

Are you using any products containing glycolic acid?_____

Are you using any products containing any alpha-hydroxy acids?_____

Are you using any products containing hydroquinone?_____

Are you using Retin-A or retinoic acid?_____

Do you prefer milky or foamy cleanser?_____

When was your last menstrual cycle?_____

How would you describe your skin type? Dry Normal Oily Combination

How does your skin feel at the end of the day? Dry Normal Oily Combination