

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Intake Form**

Age: \_\_\_\_\_

Weight: \_\_\_\_\_

Referred by: (First and last name) \_\_\_\_\_

Primary Medical Physician: \_\_\_\_\_

In which city/state? \_\_\_\_\_

Please describe the reason for this visit to the dermatologist:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Personal/Family Medical History**

**In yourself?**

**In your family? (Specify who)**

**Have you experienced:**

N

Y \_\_\_\_\_

Skin Cancer (If yes please specify type): \_\_\_\_\_

N

Y \_\_\_\_\_

Other Cancer (If yes please specify type): \_\_\_\_\_

N

Y \_\_\_\_\_

Eczema/Psoriasis (Circle one)

N

Y \_\_\_\_\_

Seasonal allergies, asthma, hay fever (Circle one)

N

Y \_\_\_\_\_

Difficulties with scarring or keloids

N

Y \_\_\_\_\_

Do you have or suspect you have HIV/AIDS/Hepatitis C?

N

Y \_\_\_\_\_

Female patients: please inform your doctor if you are pregnant, or plan on becoming pregnant during your treatment period.

N

Y \_\_\_\_\_

Have you taken Accutane in the last 12 months?

\_\_\_\_\_

Past surgical history/hospitalizations and dates:

\_\_\_\_\_

\_\_\_\_\_

Please list all other conditions for which you are currently receiving treatment:

\_\_\_\_\_

\_\_\_\_\_



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Please list all medications you are currently taking:


**Allergies**

Medication Allergies/Adverse Reactions:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Social History**

**Marital status:** Single Married Divorced Domestic Partner Separated Widowed

**Occupation:** \_\_\_\_\_

**Tobacco/Chew/Snuff use:** Yes No **Alcohol Use:** Yes No Occasional

Type: \_\_\_\_\_ Amount: \_\_\_\_\_

Amount: \_\_\_\_\_ How often: \_\_\_\_\_

How often: \_\_\_\_\_

**Have you ever used a sun tanning booth?** Yes No

**If you currently use a sun tanning booth, how often do you go?** \_\_\_\_\_

**History of blistering sunburns?** Yes No

**Contact Information**

**If we need to get in touch with you regarding test results Monday-Friday, 8:00AM-5:00PM, what is the best way to reach you?**

(Please circle one.) HOME CELL WORK EMAIL

Please enter the contact phone number &/or email here:

\_\_\_\_\_

**If you do not answer, do we have permission to leave a message with personal information?** Yes No

Pharmacy Information Name \_\_\_\_\_ Location \_\_\_\_\_

Phone number (if known): (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_