

Doctors Dermatology

PATIENT INTAKE FORM

Printed Patient Name: _____ Date of Birth: _____
 Home address: _____
 _____ City/State: _____ Zip: _____
 Primary phone #: _____ Secondary phone #: _____
 E-mail Address: _____

Reason for Visit: _____ Todays Date: _____
HOW DID YOU LEARN ABOUT US? Google, newspaper, other): _____
 Primary Care Physician/Referring Physician: _____

Insurance Information:
 Name of insurance: _____ Group #: _____
 Name of policyholder: _____ Member ID: _____
 Secondary insurance: _____

Preferred Pharmacy:
 Name: _____ Location: _____

Emergency Contact:
 Name: _____ Relationship: _____
 Phone number: _____

CURRENT MEDICATIONS:(Include Vitamins, supplements, OTC medications):

•	•
•	•
•	•
•	•

MEDICATION ALLERGIES: **No Known Allergies** If yes, complete below:

Name of medication	Type of reaction

MEDICAL HISTORY:

Skin Cancer/Other Cancer:	Immunological disease:
Melanoma/Squamous Cell Carcinoma/ Actinic Keratosis/Other Cancer	Immune deficiency:
Cancer type:	HIV/AIDS:
Date:	
Location:	Rheumatological Disease
Treatment:	Specify:
Dermatological Disease	Psychological / Emotional Disease
Psoriasis	Depression
Eczema	
Acne/Rosacea	Other:

Other:	Gastrointestinal Disease
Cardiovascular Disease:	Crohns Disease/Ulcerative Colitis
High Blood pressure	Other:
Heart attack: _____ Date: _____	Hematology Disease
Other:	Bleeding Problems:
Neurological Disease	Endocrine Disease
Stroke/Aneurysm	Diabetes
Seizure/Epilepsy	Hypothyroid/Hyperthyroid
Other:	Liver Disease
Kidney disease	Hepatitis: _____ Type: _____
Poor functioning kidneys	Other:
Dialysis:	Lung Disease
Female patients	Asthma
Are you pregnant? Yes No	COPD
Are you planning pregnancy? Yes No	Tuberculosis
Polycystic Ovarian Disease: Yes No	Others: Not Listed:

SURGERIES:

Procedure	Date

FAMILY MEDICAL HISTORY: (PLEASE ADD ANY OTHERS NOT LISTED)

Condition/Problem	Family Member affected
Melanoma	
Non-melanoma skin cancer	
Autoimmune disorder	
Psoriasis	
Other:	

SOCIAL HISTORY / HABITS

Occupation: _____
 Smoker: Non-Smoker; _____ packs/day; Smokeless tobacco: _____ Quit smoking _____
 Alcohol use: NO YES (# of drinks per week _____)
 Recreational Drug Use: NO YES, specify name _____
 I have traveled outside the United States in the past three months: YES NO
 Sunscreen Use: Regularly Rarely Never SPF #: _____

 Signature (Patient/Legal Guardian)

 Relationship to Patient

 Patient Printed Name

 Date