Patient Name: _____ DOB: _____

Past Medical History: (please circle all that apply)

Anxiety	High Blood Pressure
Arthritis	HIV/AIDS
Asthma	High Cholesterol
Atrial fibrillation	Hyperthyroidism
Bone Marrow Transplantation	Hypothyroidism
Breast Cancer	Leukemia
Colon Cancer	Lung Cancer
COPD	Lymphoma
Coronary Artery Disease	Prostate Cancer
Depression	Radiation Treatment
Diabetes	Seizures
End Stage Renal Disease	Stroke
GERD	Valve Replacement
Hearing Loss	**None**
Hepatitis	

Other: _____

Skin Disease History: (please circle all that apply)

Acne	Hay Fever/Seasonal Allergies
Actinic Keratosis	Melanoma
Basal Cell Skin Cancer	Atypical or Dysplastic Moles
Blistering Sunburns	Psoriasis
Dry Skin	Rosacea
Flaking or Itchy Scalp	Squamous Cell Skin Cancer
Eczema	**None**

Other: _____

What is the primary concern for your visit today?: _____

_____

I am bothered by: (please circle all that apply)

Fine Lines/Wrinkles	Aging Skin
Skin Texture	Thin/Short Eyelashes
Scars	Unwanted Moles
Hyperpigmentation (Brown Spots)	**None**

Do you **regularly** wear Sunscreen?	Yes	No
Do you tan in a tanning salon?	Yes	No
Do you have a family history of Melanoma?	Yes	No

If yes, which relative(s)? _____

Please turn page over and complete the other side…Thanks! ➔

History and Intake Form

Medications: Please CLEARLY print all current medications OR give us a list that we can copy

_____

_____

_____

_____

_____

_____

_____

Allergies to Medications:

_____

_____

_____

Social History:

Cigarette Smoking:

Current Every Day
Current Some Day Smoker
Former smoker
Never smoked

Occupation (environment can be relevant to skin conditions) : _____

Coordination of Care:

Preferred Pharmacy name & location: _____

Name of your primary care or family doctor (PCP/GP): _____

Marketing:

How did you hear about our office? (Example: Google, Yelp, Facebook, Insurance, Friend): _____

Name of referring Physician (If applicable): _____

Thank you! Please return form to the front desk when complete.