SKINCARE PHYSICIANS®

Patient Intake and History Form

Name: _____ Date of Birth: _____

Occupation: _____

Home Phone #: _____ Mobile Phone #: _____Work Phone #: _____

Ok to leave messages: YES / NO

Preferred Language: _____ Race: American Indian/White/Asian/Black/African American/Native Hawaiian

Ethnic Group: Decline to specify/ Hispanic or Latino/ Not Hispanic or Latino/ Unknown

Preferred Pharmacy_____

Name: _____

Phone Number: _____

City or Zip Code: _____

Primary Care Physician/Referring Provider

Name: _____

Address: _____

City/Zip/Phone Number: _____

Past Medical History

Select any of the following medical conditions you currently have:

- ☐ Anxiety
- ☐ Migraines
- ☐ Asthma
- ☐ Diabetes
- ☐ Stroke
- ☐ Bleeding Disorder
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV / AIDS
- ☐ Gold Therapy for Arthritis
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ NONE
- ☐ Pacemaker

Other:

_____

_____

_____

Past Surgical History:

Skin Disease History

Have you had any of the following?

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Eczema
- ☐ Basal Cell Skin Cancer
- ☐ Squamous Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Psoriasis
- ☐ Melanoma
- ☐ Other: _____

Do you wear Sunscreen?

○ Yes ○ No If Yes, what SPF? _____

Do you tan in a tanning salon?

○ Yes ○ No

Do you have a family history of Skin Cancer?

○ Yes ○ No

If yes, which relative? _____

PLEASE TURN OVER

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Medications

List all current medications:

_____
_____
_____

Allergies

List all allergies and reactions if known:

_____
_____
_____

Social History

Smoking Status (please choose one):

- ☐ Current every day smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Unknown if ever smoked

Alcohol Intake (please choose one):

- ☐ None
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day

Have you received the Pneumonia Vaccine: YES / NO