skin
PHYSICIANS
& SURGEONS

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Office use only
revisions to intake sheet
___/___/___by_____
___/___/___by_____
___/___/___by_____

Name: _____ D.O.B. _____ Age:_____ Date:_____

Name of referring physician: _____ Specialty: _____

City: _____ Phone # (if available) _____

List any medication you may be allergic to:_____

_____

List all medications you are currently taking:_____

_____

_____

Do you have, or ever had diseases/disorders of the following?

	YES	NO		YES	NO
Heart	☐	☐	Blood system / Clotting	☐	☐
Lungs	☐	☐	Blood sugar / Diabetes	☐	☐
Stomach / Bowel	☐	☐	Depression	☐	☐
Kidneys	☐	☐	Thyroid	☐	☐
Joints / Muscles	☐	☐	Blood Pressure	☐	☐
Liver	☐	☐	Cancer (non-skin)	☐	☐
Infectious disease (HIV, Hepatitis)	☐	☐	Reproductive Organs	☐	☐

Please list any chronic your specific medical problems you have (i.e. Cancer, Diabetes, Stent, Joint Replacement, Artificial Heart Valve, Blood Clot, Lupus, etc.): _____

_____

_____

_____

What is/was your occupation(s)?_____

	YES	NO
Do you have a history of skin cancer? If so, what type?_____	☐	☐
Is there a family history of melanoma?	☐	☐
Do you have a history of a specific skin disease? If so, what type?_____	☐	☐
Do you form Keloids or hypertrophic thick scars?	☐	☐
Do you take aspirin or blood thinners?	☐	☐

	YES	NO
Do you smoke cigarettes or use tobacco?	☐	☐
Do you drink regularly?	☐	☐

Females

Are you pregnant?	☐	☐
Are you trying to become pregnant?	☐	☐
Are you breast feeding?	☐	☐
Do you take birth control pills?	☐	☐

Preferred pharmacy phone number: _____ Do you prefer ☐ brand name or ☐ generic prescriptions?

Signature:_____Date_____
(Patient/parent/guardian)