Patient Intake Form

MD SkinCenter
Dermatology • Mohs • Facial Plastic Surgery

First & Last Name: _____ Occupation: _____

Date of Birth: _____ Race: _____

Preferred Pharmacy: _____ Preferred Language: _____

Medical History

- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Blood clots (DVT)
- ☐ Breast cancer
- ☐ Colon cancer
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ GERD (Reflux)
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Other _____
- ☐ Liver Disease
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Therapy
- ☐ Renal Disease
- ☐ Seasonal Allergies
- ☐ Seizures
- ☐ Stroke (CVA)

Medication List:

(you may attach a list)

_____
_____
_____
_____
_____
_____
_____
_____
_____

Are you pregnant? Yes / No
Are you breastfeeding ? Yes / No

Allergies:

_____
_____
_____
_____
_____

Surgical History

- ☐ Artificial Heart Valve | Date _____
- ☐ Joint Replacement | Date/Joint _____
- ☐ Pacemaker/Defibrillator | Date _____
- ☐ Organ Transplant | Date/Organ _____
- ☐ Other Major Surgeries _____

Skin History

- ☐ Melanoma | Date/Location _____
- ☐ Squamous Cell Carcinoma
- ☐ Basal Cell Carcinoma
- ☐ Atypical Moles (Dysplastic Nevi)
- ☐ Acne
- ☐ Eczema
- ☐ Psoriasis

Have you used tanning beds (past or present)? Yes / No

Do you have a family history of Melanoma? Yes / No

Previous Dermatologist: _____

Smoking Habits

- ☐ Never Smoker
- ☐ Former Smoker
- ☐ Current Some Day Smoker
- ☐ Current Every Day Smoker

Alcohol Use

- ☐ None
- ☐ Occasional (less than 1 drink per day)
- ☐ 1-2 drinks per day
- ☐ 3 or more drinkers per day

Cosmetic Services

Would you like more information about the cosmetic/aesthetic services we offer? Yes / No

- ☐ Laser Hair Removal / Lasers for Pigmentation
- ☐ Skin Resurfacing / Tightening
- ☐ Botox / Filler Injectables
- ☐ Facials / Chemical Peels