Patient Intake Form

MD SkinCenter
Dermatology • Mohs • Facial Plastic Surgery

First & Last Name: _____ Occupation: _____

Date of Birth: _____ Race: _____ Height: _____

Preferred Pharmacy: _____ Preferred Language: _____ Weight: _____

Medical History

- [ ] Anxiety
- [ ] Arthritis
- [ ] 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
- [ ] Other _____
- [ ] Hypothyroidism
- [ ] Liver Disease
- [ ] Lymphoma
- [ ] 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 | Year _____
- [ ] Joint Replacement | Year/Joint _____
- [ ] Pacemaker/Defibrillator | Year _____
- [ ] Organ Transplant | Year/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 / Present / Never (circle one)

Do you have a family history of Melanoma? Yes / No (circle one)

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 drinks 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