Date:______________ MRN:________________

Patient Name: ________________________________
Last Name First Name M.I.

Intake New Patient Form

Referring Provider:______________________________

Medication Allergies:____

Reason for today's visit:____

____

CURRENT SYMPTOMS/CONDITIONS

Please mark all that apply.

Abdominal pain	Y	N	Defibrillator	Y	N	Premedication prior to procedure required	Y	N
Allergy to adhesive	Y	N	Depression	Y	N			
Allergy to lidocaine	Y	N	Fever or chills	Y	N	Problems with scarring	Y	N
Allergy to topical ointments	Y	N	GI upset w/antibiotics	Y	N	Problems with healing	Y	N
			Hay fever/seasonal allergy	Y	N	Problems with bleeding	Y	N
Anxiety	Y	N	Headaches	Y	N	Rash	Y	N
Artificial heart valve	Y	N	Immunosuppression	Y	N	Rapid heartbeat with epinephrine	Y	N
Artificial joint past 2 years	Y	N	Joint aches	Y	N			
Blood thinners	Y	N	MRSA	Y	N	Seizures	Y	N
Bloody stool	Y	N	Muscle weakness	Y	N	Shortness of breath	Y	N
Bloody urine	Y	N	Neck stiffness	Y	N	Sore throat	Y	N
Blurry vision	Y	N	Night sweats	Y	N	Thyroid problems	Y	N
Changing mood	Y	N	Pacemaker	Y	N	Unintentional weight loss	Y	N
Chest Pain	Y	N	Pregnancy	Y	N	Wheezing	Y	N
Cough	Y	N						

SKIN DISEASE HISTORY

Please mark all that apply.

Acne	Y	N	Dry Skin	Y	N	Poison Ivy	Y	N
Actinic keratosis	Y	N	Eczema	Y	N	Precancerous moles	Y	N
Asthma	Y	N	Flaking/Itchy scalp	Y	N	Psoriasis	Y	N
Basal cell skin cancer	Y	N	Hay fever/Allergies	Y	N	Squamous cell cancer	Y	N
Blistering sun burns	Y	N	Melanoma	Y	N		Y	N

Do you wear sunscreen: Y N What SPF?____________

Do you tan in a tanning salon? Y N

Do you have a family history of Melanoma? Y N Which relative?____________________________________

SMOKING HABITS			TOBACCO USE			ALCOHOL USE		
Do you Smoke?	Y	N	Do you use Tobacco?	Y	N	Do you drink Alcohol?	Y	N
How many packs per day?_______			How many times per day?________			Average drinks per week ______		
Have you Smoked in the past?	Y	N	Have you used Tobacco in the past?	Y	N	Did you drink Alcohol in the past?	Y	N
When did you quit?___________			When did you quit?____________			When did you quit?_________		

Please complete both Front and Back of the form

MRN:________________

MEDICAL HISTORY

Have you had any of the following Medical conditions in the past?

Condition	Y	N	Condition	Y	N	Condition	Y	N
Anxiety	Y	N	Coronary artery disease	Y	N	High cholesterol	Y	N
Arthritis	Y	N	Depression	Y	N	Overactive thyroid	Y	N
Asthma	Y	N	Diabetes	Y	N	Underactive thyroid	Y	N
Atrial fibrillation	Y	N	End stage kidney disease	Y	N	Radiation treatment	Y	N
Bone marrow transplant	Y	N	Gerd (acid reflux)	Y	N	Seizures	Y	N
BPH (enlarged prostates)	Y	N	Hearing loss	Y	N	Stroke	Y	N
Cancer (list type below)	Y	N	Hepatitis/Liver disease	Y	N	Other (list type below)	Y	N
____________________			High blood pressure	Y	N	____________________		
____________________			HIV/AIDS	Y	N	____________________		
COPD	Y	N						

Surgical history

Please mark all that apply.

Procedure	Y	N	Procedure	Y	N	Procedure	Y	N
Lumpectomy	Y	N	Heart valve replacement	Y	N	Kidney removed	Y	N
Location:__________________			Heart transplant	Y	N	Kidney transplant	Y	N
Mastectomy	Y	N	Heart shunt	Y	N	Liver transplant	Y	N
Location:__________________			Hysterectomy			Liver shunt	Y	N
Gallbladder removed	Y	N	Joint replacement	Y	N	Prostate biopsy	Y	N
Heart bypass	Y	N	Location:__________________			Prostate removal/cancer	Y	N
Heart angioplasty	Y	N	Kidney biopsy	Y	N	Skin surgical procedure	Y	N
						Location:__________________		

FAMILY MEDICAL HISTORY

Please check all that apply.

	Mother	Father	Sibling	Child	Uncle/Aunt	Grandparent
Acne						
Arthritis						
Asthma						
Diabetes						
Eczema						
Hay fever/Allergies						
Lupus						
Psoriasis						
Non-melanoma skin cancer						

Emergency Medical Contact:______________________ / ____________________ Phone No.__________________
Name Relationship

Emergency Medical Contact:______________________ / ____________________ Phone No.__________________
Name Relationship

Preferred Pharmacy:______________________________________ Pharmacy Phone #:____________________

Pharmacy Address:____

Please complete both Front and Back of the form