Acclaim Dermatology Intake Form

Patient Name: _____ **Preferred Name: _____**
Height: _____ Weight: _____ **Date of Birth: _____ Age: _____**
Sex: _____ Marital Status: _____ **Occupation: _____**
Email: _____ **Phone Number: _____**
Patients Address: _____
***If a minor,* Parents Name:_____** **Referred by: _____**
Primary Physician: _____ **Phone Number: _____**
Preferred Pharmacy: _____ **Phone Number: _____**
Address: _____ **City:_____ Zip Code:_____**

Alerts: Please Check yes or no

Artificial heart valve or joints ___Y ___N
Pacemaker or Defibrillator Present ___Y ___N
Rapid heartbeat with epinephrine ___Y ___N
Blood Thinners ___Y ___N
Premedication prior to procedures ___Y ___N

Women only:

Pregnancy, planning a pregnancy or breast feeding ___Y ___N
Last Menstrual Period: _____

Past Medical History: (please check all that apply)

___ NONE

___ Anxiety	___ Arthritis	___ Asthma	___ Irregular Heartbeat
___ Bleeding Disorder	___ Bowel Disease	___ Cancer: _____	___ COPD
___ Depression	___ Diabetes	___ Immunosuppression	___ Kidney Disease
___ GERD	___ Headaches	___ Hearing Loss	___ Hepatitis
___ High Blood Pressure	___ HIV/AIDS	___ High Cholesterol	___ Hyperthyroidism
___ Heart Disease	___ Leukemia	___ Lupus	___ Lymphoma
___ Liver Disease	___ Radiation Treatment	___ Seizures	___ Stroke

*Other:*_____
_____

Past Surgical History: (Please Check all that apply)

___ NONE

___ Appendix Removed	___ Joint Replacement within last 2 years
___ Kidney Stone Removal	___ Kidney Transplant
___ Breast Reduction	___ Hysterectomy
___ Breast Implants	___ Gallbladder Removed
___ Coronary Artery Bypass	___ Mechanical Valve Replacement
___ Heart Transplant	___ Spleen Removed

Other: _____
_____

Skin Disease History: (please check or circle all that apply)

___ NONE

___ Acne ___ Actinic Keratosis ___ Basal Cell Carcinoma
___ Blistering Sunburns ___ Dry Skin ___ Eczema ___ Flaking or Itchy Scalp
___ Hay Fever/Allergies ___ Melanoma ___ Poison Ivy ___ Precancerous Mole
___Psoriasis ___ Skin Biopsy ___ Squamous Cell Carcinoma

Other: _____

Do you wear Sunscreen? Yes or No *If yes, what SPF?* _____ **Do you tan in a tanning salon?** Yes or No

Do you have a family history of Melanoma? Yes or No *If yes, which relative(s)?*_____

_____

Any other family history: _____

_____

Medications: (Please enter all current medications)

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Medication Allergies: (include reaction)

_____ _____
_____ _____

Social History: (Please check all that apply)

Cigarette Smoking:

___ Never ___ Former smoker ___Smokes daily

Alcohol Use:

___None ____Social ____Heavy

Illicit Drug Use:

____ Never ___ Drug Use ___ IV Drug Use

In Case of Emergency:

Name: _____ Phone Number: _____

Relationship to patient: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Acclaim Dermatology or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature **Date:**