COLORADO CENTER for DERMATOLOGY & SKIN SURGERY

Patient Information Intake Form

Last Name:	First Name:
Middle Name:	DOB (MM/DD/YYYY):
Nickname:	Social Security #:
Sex:	Preferred Language:
Race:	Ethnic Group:
Home Phone:	Work Phone:
Mobile Phone:	Preferred Contact (circle one): Home | Work | Mobile
I would like to receive text messages (circle one): YES | NO	
Email Address:	
Home Address:	
City: State: Zip:	
Seasonal Address, City, State, Zip: *Is Your Mail Forwarded?* YES | NO	
Occupation: Employer/School:	
Marital Status (circle one): Single | Married | Separated | Divorced | Widowed	
Spouse's Name: *Phone:*	
Spouse's Occupation/Employer:	
Emergency Contact Name:	
Relationship: Phone:	
RESPONSIBLE PARTY (if other than patient):	
Name:	Relationship:
DOB:	Social Security #:
Home/Cell Phone:	Work Phone:
REFERRAL INFORMATION: (Please circle below to help us determine how you were referred to our office.)	
Physician | Friend | Relative | One of Our Patient's | Referral Service | Insurance | Newspaper | Our Website Internet (specify search engine):_____ | Other (please specify):_____	
Referring Physician: Name & Address: Phone:	
Primary Care Physician: Name & Address: Phone:	
Preferred Pharmacy: Name & Address: Phone:	

Contact Information:

Do you give our office permission to discuss your medical information with family members, including but not limited to: biopsy results, blood/lab results, or other test results? **YES | NO** If, YES:

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

Do you give permission for Colorado Center for Dermatology & Skin Surgery's staff to leave detailed messages at your preferred contact number regarding any tests that you may incur as a patient, including but not limited to: biopsy results, blood/lab results, or other test results? **YES | NO**

Signed (Patient or Legal Representative) _____ **Dated** _____

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Patient Health History Form

Today's Date: _____

Patient's Full Name:_____ **Date of Birth**: _____ **Age**: _____

Medication Allergies: _____

Reason for Today's Visit: _____

Have you previously been diagnosed with any of the following? If you have experienced any other medical problems that are not in the following list, please list/describe in the section entitled "Other."

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation (Irregular Heartbeat)
- ☐ BPH (Enlarged Prostate)
- ☐ Bone Marrow Transplant
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Heart Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD (Acid Reflux)
- ☐ Hearing Loss
- ☐ Heart Valve Replacement
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Joint Replacement
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Stroke

Other:_____

Hospitalizations & Surgical History:

Reason:	Date:
Reason:	Date:

Have you had the following vaccinations?

- ☐ Influenza Date of Most Recent Vaccination: _____
- ☐ Pneumonia Date of Most Recent Vaccination: _____

Have you had any of the following skin conditions?

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Asthma
- ☐ Basal Cell Carcinoma
- ☐ Blistering Sunburn
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaky/Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Carcinoma

Other:_____

List all medications you are currently taking (including prescriptions, over-the-counter, vitamins, and herbals). Please include dosage and frequency.

1.	4.
2.	5.
3.	6.

During your visit today, would you like to learn about skin care treatments and/or products to optimize the health and appearance of your skin? YES NO AT A LATER DATE

Is there anything else you would like us to know or you would like to discuss today?

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Family History: Has anyone in your family ever had any of the following conditions?

	Associated Family Member:		Associated Family Member:
☐ Alzheimer's	_____	☐ Kidney Disease	_____
☐ Arthritis	_____	☐ Liver Disorder	_____
☐ Asthma	_____	☐ Lung Disorder	_____
☐ Cancer	_____	☐ Melanoma	_____
☐ Depression	_____	☐ Osteoporosis	_____
☐ Diabetes	_____	☐ Skin Cancer	_____
☐ Heart Disease	_____	(type:_____)	_____
☐ High Blood Pressure	_____	☐ Stroke	_____
☐ High Cholesterol	_____	☐ Thyroid Disorder	_____

Other Details:_____

Lifestyle Factors:

1. Do you use sunscreen?	Yes	No	If Yes, specify SPF: _____ If Yes, is it zinc-based? YES | NO
2. Do you use a tanning bed?	Yes	No	If Yes, how often?
3. Have you ever smoked?	Yes	No	If Yes, # of years:_____;# of packs/day_____
a. Do you smoke now?	Yes	No	If Yes, # of packs/day_____
4. Do you use recreational drugs?	Yes	No	If Yes, types:_____;# times/week_____
5. Do you drink alcohol?	Yes	No	If Yes, # drinks/day:_____
6. Do you exercise?	Yes	No	If Yes, # times/week_____

Review of Systems/Alerts Information:

a. Do you develop skin rashes or reactions to: Medications | Food | Environment | Bandages

Please Describe: _____

b. Do you develop keloid scars? (firm, thick scars)	Yes	No	
c. Do you bleed easily?	Yes	No	If Yes, are you on blood thinners? YES | NO
d. Do you have an Artificial Heart Valve?	Yes	No	
e. Have you had Artificial Joints in the last 2 years?	Yes	No	
f. Do you have a Defibrillator or Pacemaker?	Yes	No	
g. Do you have a history of MRSA infection?	Yes	No	
h. Do you require antibiotics prior to procedures?	Yes	No	
i. Do you develop rapid heartbeat to epinephrine (e.g., EpiPen)?	Yes	No	
j. For Women: Are you pregnant?	Yes	No	
k. For Women: Are you breastfeeding?	Yes	No	

Signed (Patient or Legal Representative) _____ **Dated** _____