



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 Phone (circle one): Home Work Mobile	
Email Address:		Preferred Contact (circle one): Phone Email Patient Portal	
Home Address:			
City:		State:	Zip:
Seasonal Address, City, State, Zip: Start Date: _____ End Date: _____ (Is 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:		Phone:	
Caretaker Name:		Phone:	
RESPONSIBLE PARTY/GUARANTOR (if other than patient):			
Name:		DOB:	Relationship:
Address (inc. City, State, Zip):			
Email:		Phone: Home Work Mobile	
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 Our Website Prior Patient Internet (specify search engine): _____ Other (please specify): _____			
Referring Physician:			
Name & Address:		Phone:	
Primary Care Physician:			
Name & Address:		Phone:	
Preferred Pharmacy:			
Name & Address (City, Zip):		Phone:	
In-Network Lab:		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 phone 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** _____



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."

- Checkboxes for various medical conditions: Anxiety, Arthritis, Asthma, Atrial Fibrillation, BPH, Bone Marrow Transplant, Breast Cancer, Colon Cancer, COPD, Coronary Heart Disease, Depression, Diabetes, End Stage Renal Disease, GERD, 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?

- Checkboxes for Influenza and Pneumonia, with fields for Date of Most Recent Vaccination.

Have you had any of the following skin conditions?

- Checkboxes for various 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.

Table with 2 columns and 6 rows for listing medications.

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?



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

	<u>Associated Family Member:</u>		<u>Associated Family Member:</u>
<input type="checkbox"/> Alzheimer's	_____	<input type="checkbox"/> Kidney Disease	_____
<input type="checkbox"/> Arthritis	_____	<input type="checkbox"/> Liver Disorder	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Lung Disorder	_____
<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> Melanoma	_____
<input type="checkbox"/> Depression	_____	<input type="checkbox"/> Osteoporosis	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Skin Cancer	_____
<input type="checkbox"/> Heart Disease	_____	(type: _____)	_____
<input type="checkbox"/> High Blood Pressure	_____	<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> High Cholesterol	_____	<input type="checkbox"/> 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. <u>For Women:</u> Are you pregnant?	Yes	No	
k. <u>For Women:</u> Are you breastfeeding?	Yes	No	

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