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 (inc. Apt. #):	
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**: _________

Reason for Today's Visit: ____

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

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.

List all Medication Allergies: ____

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

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/used tobacco?	Yes	No	If Yes, # of years:_______;# of times/day_____
a. Do you smoke/use tobacco now?	Yes	No	If Yes, # of times/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________________________

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:____

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** __________________________