



**DERMATOLOGY ASSOCIATES
NEW PATIENT INFORMATION (ADULT)**

Intake Form (Adult)

Age: _____

Weight: _____

Referred by: (first and last name)

Patient Name: _____ Date of Birth: _____

Primary Medical Physician:

_____ In which city/state? _____

Please describe the reason for this visit to the dermatologist: _____

Personal / Family Medical History

Have you experienced:	In yourself?	In your family? (specify who)
Skin Cancer (if yes please specify type): _____	N Y	_____
Other Cancer (if yes please specify type): _____	N Y	_____
Eczema / Psoriasis (circle one)	N Y	_____
Seasonal allergies, asthma, hay fever (circle one)	N Y	_____
Difficulties with bleeding or clotting (circle one)	N Y	_____
Difficulties with scarring or keloids	N Y	_____
Do you have or suspect you have HIV/AIDS/Hepatitis C?	N Y	_____

Female patients: please inform your doctor if you are pregnant, or plan on becoming pregnant during your treatment period.
N Y _____

Please list all other conditions for which you are currently receiving treatment:

Past surgical history / hospitalizations and dates: _____

Please list all other conditions for which you are currently receiving treatment:

For office use only:	
_____	_____
Initials	Date



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Past surgical history / hospitalizations and dates:

Patient Name: _____
Date of Birth: _____

Please list all medications you are currently taking:

Allergies / Adverse Reactions

- 1. Food allergies: _____
- 2. Medication allergies (please list reaction, if known): _____

Social History

Martial Status: Single Married Divorced Domestic Partner Separated Widowed

Occupation: _____

Tobacco / Chew / Snuff use: N Y
Type: _____
Amount: _____
How often: _____

Alcohol Use: N Y Occasional
Amount: _____
How often: _____

Have you ever used a sun tanning booth? N Y

If you currently use a sun tanning booth, how often do you go? _____

Contact Information

If we need to get in touch with you regarding test results M-F, 8-5, what is the best way to reach you? (Please circle one.) HOME CELL WORK EMAIL

Please enter the contact number/email here: _____

If you are not at home, do we have permission to leave a message with personal information? N Y

Pharmacy: (name) _____ (location) _____

Phone number (if known): (_____) _____ - _____

Patients: Please fill in date this form was completed:

_____/_____/_____
Month Day Year

OFFICE USE ONLY: Reviewed, and all pertinent positives discussed with patient.