DERMATOLOGY PATIENT INTAKE SURVEY

PATIENT NAME:_____ Date of Birth:_____/_____/_____

(IF PATIENT IS A MINOR): YOUR NAME:_____ RELATIONSHIP TO PATIENT:_____

PERSONAL PHONE NUMBER(S): _____

MAY WE LEAVE A MESSAGE WITH MEDICAL INFORMATION ON YOUR ANSWERING MACHINE? Y/N_____

WOMEN: COULD YOU BE PREGNANT/ BREASTFEEDING/ ARE YOU THNKING OF BECOMING PREGNANT? Y/N_____

REASON FOR TODAY'S VISIT:_____

WHEN DID THIS PROBLEM START?_____

WHAT TREATMENTS HAVE BEEN TRIED?_____

DOES ANYTHING MAKE IT WORSE?_____

ANY ASSOCIATED SYMPTOMS? PAIN/ITCHING/BURNING/OTHER_____

LIST ANY ALLERGIES TO MEDICATIONS OR LATEX:_____

ARE YOU EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS?

FEVERS / CHILLS / SWEATS / UNINTENTIONAL WEIGHT LOSS / NAUSEA / VOMITTING/ HEADACHES / CHANGES IN VISION / CHANGES IN HEARING / CHEST PAIN / DIFFICULTIES BREATHING / OTHER: _____

DO YOU HAVE A HISTORY OF ANY SKIN RELATED CONDITIONS?

ECZEMA / ASTHMA / ALLERGIES PSORIASIS MELANOMA SKIN CANCER KELOIDS LUPUS OTHER _____

PLEASE LIST ANY **PRIOR OR CURRENT MEDICAL PROBLEMS**:

_____

PLEASE LIST ANY PRIOR **SURGERIES:**

_____

DOES ANYONE IN YOUR FAMILY HAVE A HISTORY OF ANY OF THE FOLLOWING SKIN RELATED CONDITIONS?

ECZEMA / ASTHMA / ALLERGIES PSORIASIS MELANOMA SKIN CANCER OTHER _____

DO YOU DRINK ALCOHOL? HOW MANY DRINKS/ WEEK?_____

DO YOU USE TOBACCO PRODUCTS? WHAT TYPE AND HOW MUCH/DAY?_____

DO YOU GO TO TANNING PARLORS/USE TANNING BEDS?_____

PLEASE REVIEW THE MEDIATION RECONCILIATION LIST, CROSS OUT ANY MEDICATIONS YOU NO LONGER TAKE AND ADD ANY ADDITONAL MEDICATIONS, VITAMINS OR SUPPLEMENTS YOU ARE TAKING (INCLUDING OVER-THE-COUNTER)