Patient History and Intake Form

Name: ________________________________Age: ______DOB: _____/_____/_____ Date: _________

Reason for today's visit:

1.___________________________________ 3.___________________________________
2.___________________________________ 4.___________________________________

Past Medical History (check each box that applies)

Condition	Personal	Family	Condition	Personal	Family
Acne			High blood pressure		
Anxiety			High cholesterol		
Arthritis			HIV/AIDS		
Artificial joints			Keloids		
Asthma			Liver disease		
Atopic dermatitis			Lung disease		
Autoimmune			Multiple sclerosis		
Explain:___________________			Psoriasis		
Bleeding disorder			Radiation therapy		
Clotting disorder			Rosacea		
Cancer			Thyroid disorder		
Explain:___________________			Transplant		
Crohn's/Colitis			*Other, including surgeries:* ___________________		
Celiac disease			____		
Diabetes			____		

Skin Cancer History

Have you seen a dermatologist before?	YES	NO
Have you had an atypical mole removed before?	YES	NO
Have you ever had precancerous/actinic keratosis?	YES	NO
Have you ever had a skin cancer?	YES	NO
Melanoma	Location/Date: ________________________________	
Basal Cell	Location/Date: ________________________________	
Squamous cell	Location/Date: ________________________________	
Do you have a family history of Melanoma?	YES	NO
If yes, which relative (s)? ________________________________		
Do you wear sunscreen?	YES	NO
Have you ever used indoor tanning beds?	YES	NO

ONESKIN DERMATOLOGY

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Other Medical History

Have you had any joints replaced in the past 2 years?	YES	NO
Do you have a pacemaker/defibrillator?	YES	NO
Did you have heart surgery as an infant/child?	YES	NO
Do you have an artificial heart valve?	YES	NO
Have you ever had an infected heart valve?	YES	NO
Do you get cold sores?	YES	NO

Medications & Supplements

1. __________________________
2. __________________________
3. __________________________
4. __________________________

Allergies To Medications (reaction type)

1. __________________________
2. __________________________
3. __________________________
4. __________________________

Social History

Occupation:_____________________________

Hobbies:________________________________

Recreational drug use? **Yes** **No**

If yes, provide details:_________________

Drink alcohol? **Yes** **No**

How much alcohol per week? _________

Smoke tobacco? **Yes** **No**

How many packs per day? ____________

Family Planning (females only)

Are you pregnant?	**YES**	**NO**
Planning pregnancy or nursing?	**YES**	**NO**
Form of contraception ___________		**NONE**
Regular periods:	**YES**	**NO**

Additional information: At OneSkin Dermatology we hope to become the home for all of your skin's needs. We want to know any information that will allow us to take the best care of *all* of you if you can please share below. Examples include, any negative healthcare experiences, fear of needles, preference for natural treatment options:

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We look forward to meeting you!

Your OneSkin Dermatology Team

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