THE CENTER FOR **ENT**
Dermatology

DERMATOLOGY INTAKE FORM

Patient Name: ______________________________ Date of Birth: ______________

How did you hear about us? Please list referring doctor, if applicable: ______________________________

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What treatment, if any, are you currently on for the above concern?: ______________________________

Please list all over-the-counter and prescription treatments: ______________________________

Other concerns (Please list no more than two additional concerns): ______________________________

Please note, we will try to address all of your concerns, but if you have more than three separate issues, we may ask you to schedule another appointment. We want to make sure that we have adequate time to address all of your concerns in detail.

Medications: ______________________________

Allergies, including medication allergies: ______________________________

Do you have a history of skin cancer or precancerous or abnormal skin lesions?: ______________________________

If so, please give details: ______________________________

Do any family members have a history of skin cancer?: ______________________________

If yes, please tell us who and what kind of skin cancer, if you know: ______________________________

Please list your medical problems: ______________________________

Please list prior surgeries. Include minor surgeries, as well as surgeries for skin cancer and cosmetic surgeries:

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Are you having any other symptoms today? Please check all that apply.

☐ Headaches
☐ Dizziness
☐ Fevers or chills
☐ Depression or anxiety
☐ Fatigue
☐ Weight changes
☐ Eye irritation
☐ Changes in vision
☐ Nosebleeds
☐ Shortness of breath
☐ Cough
☐ Muscle pain
☐ Joint pain or swelling
☐ Abdominal pain
☐ Nausea
☐ Diarrhea
☐ Leg swelling

Do you have a pacemaker or defibrillator?: ______________________________

Do you require antibiotics prior to dental or surgical procedures?: ______________________________

Females—Are you currently pregnant or breastfeeding?: ______________________________

Is it okay for us to leave messages for you regarding your medical care or test results?: ______________________________

Is there anyone else we can share your medical information, including test results, with?
Please provide their name and phone number:

1. ______________________________ 2. ______________________________