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New Patient Intake

Name: _____ Date of Birth:_____

Yes	No	
❑	❑	Are you Pregnant?
❑	❑	Are you breastfeeding?
❑	❑	Do you have a pacemaker or defibrillator?
❑	❑	Are you on chemotherapy or are you taking medications that may suppress your immune system, such as prednisone or cellcept?
❑	❑	Do you take warfarin, Coumadin, or Pradaxa?
❑	❑	Do you take aspirin or Plavix?
❑	❑	Do you bleed easily with difficulty stopping?
❑	❑	Do you have a history of MRSA?
❑	❑	Have you been instructed take antibiotics prior to procedures?
❑	❑	Do you have any replaced joints, such as a hip or a knee?
❑	❑	Do you have an artificial replacement heart valve?
❑	❑	Are you allergic to lidocaine or epinephrine?
❑	❑	Do you have any moles changing in size, shape or color?

Medical Conditions

Check any of the medical conditions listed below that you have or: ❑ None

❑ Anxiety	❑ Depression	❑ Kidney Disease
❑ Arthritis	❑ Diabetes	❑ Leukemia
❑ Asthma	❑ Enlarged Prostrate	❑ Lung Cancer
❑ Atrial Fibrillation	❑ GERD	❑ Lymphoma
❑ Bone Marrow Transplant	❑ Hearing Loss	❑ Prostate Cancer
❑ Breast Cancer	❑ Hepatitis	❑ Radiation Treatment
❑ Colon Cancer	❑ High Cholesterol	❑ Seizures
❑ COPD	❑ HIV/AIDS	❑ Stroke
❑ Coronary Heart Disease	❑ Hypertension	❑ Thyroid Disease

Other: _____

Medication

List **allergies** to medications or: ❑ No known allergies to medications

_____

_____

List all of your **prescription** medications or provide the nursing staff with a written list when you are taken back to see the doctor or: ❑ No prescription medication

_____

_____

Pharmacy of choice (to send electronic prescriptions): _____

Surgeries

Check any of the surgeries that you have had or: ❑ None

❑ Appendix
❑ Bladder

Breast
Mastectomy ❑ Right ❑ Left
Lumpectomy ❑ Right ❑ Left
❑ Bioposy
❑ Reduction
❑ Implant

Colectomy
❑ Diverticulitis
❑ Inflammatory Bowel Disease
❑ Colon cancer

❑ Gallbladder

Heart
❑ Bypass
❑ Stenting
❑ Valve Replacement
❑ Transplant

Joint Replacement
Knee ❑ Right ❑ Left
Hip ❑ Right ❑ Left

Kidney
❑ Biopsy
❑ Nephrectomy
❑ Stone Removal
❑ Transplant

❑ Hysterectomy: Endometriosis/Cancer
❑ Ovarian Cyst
❑ Ovarian Cancer

Prostate
❑ Biopsy
❑ Cancer
❑ TURP

❑ Splenectomy

❑ Testicular

Other: _____

Past Dermatology History

Previous skin biopsy(s), date/diagnosis:_____

History of Basal Cell Carcinoma (list location and year treated): _____

History of Squamous Cell Carcinoma:_____

History of Melanoma:_____

Yes	No	
❑	❑	Do you have a Family history of malignant melanoma?
❑	❑	Have you had atypical or dysplastic moles removed in the past?
❑	❑	Have you used tanning beds on a regular basis?
❑	❑	Do you consistently use a sunblock to protect you skin when outdoors?