apex DERMATOLOGY GROUP

Intake

Name: _____ Date: _____

Address: _____ _____ Zip Code: _____

Date of Birth: _____ Gender: _____

Phone Number: _____ Preferred method of communication: _____

OK to leave messages: Y N _____

Email Address: _____ _____ _____

Emergency Contact and phone number: _____

Preferred Language: _____ Race: _____ Ethnic group: _____

Preferred Pharmacy

Name: _____ Phone number: _____ Zip Cpde: _____

Primary Care Doctor: _____

apex DERMATOLOGY GROUP

Patient Name: _____

DOB: _____ **Height:** _____ **Weight :** _____

Past Medical History: (high blood pressure, diabetes, high cholesterol, etc..)

_____

Past Surgical History: _____

_____

Skin Disease History: Please circle

Basal cell Carcinoma	Melanoma	Dry skin	Psoriasis	Actinic Keratosis
Squamous Cell Carcinoma	Atypical Nevus	Eczema	Blistering sunburns	

Do you wear sunscreen : Yes No if yes, whats SPF: _____

Medications : _____

_____

_____

Drug Allergies: _____

_____

Smoking status: Current everyday Current someday Never Former

Family History of Melanoma : YES No if yes, which relative: _____

Alerts

Pregnancy or planning pregnancy	Yes	No
Pregnant or breastfeeding	Yes	No
Allergy to Adhesive	Yes	No
Allerg to Lidocaine	Yes	No
Allergy to topical antibiotic ointments	Yes	No
artificial joints within past 2 years	Yes	No
Blood thinners	Yes	No
Defibrillator	Yes	No
Pacemaker	Yes	No
MRSA	Yes	No

Review of Systems

Allergy to latex	Yes	No
Aspirin daily	Yes	No
Back pain	Yes	No
Fever/Chills	Yes	No
Immunosuppression	Yes	No
Joint pain/swelling	Yes	No
New skin lesions	Yes	No
Night sweats	Yes	No
Problems with bleeding	Yes	No
Problems with healing	Yes	No
Rash	Yes	No
Recent illness	Yes	No
unintentional weight loss	Yes	No