FOOTHILLS FAMILY DERMATOLOGY
MEDICAL SURGICAL AESTHETIC
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# New Patient Intake Form

Name:_____

Date of Birth ____/_____/_____ Age:_____ Gender:_____ Primary Language: _____

Address:_____

Cell Phone:_____ Home:_____ Work: _____ Circle preferred phone

OK to leave message? Yes No Ok to text? Yes No

Email Address: _____ Ok to email health info? Yes No

Emergency Contact:_____Relationship:_____Phone #:_____

With Whom may we discuss your health info? _____ Relationship:_____

Phone:_____

Primary Care Physician and Clinic Name:_____

Pharmacy Name and Address: _____

**Responsible Party** (the insurance policy holder, if different from patient)

Name (write "same" if same as above):_____

Relationship to Patient: _____Date of Birth:____/____/____ Sex: Male Female

Address:_____Phone: _____

**Referral Info** (how did you hear about Foothills Family Dermatology?)

Signature: _____ Date: _____

Have you had or do you currently have any of the following medical conditions (circle if applicable):

Arthritis COPD/Lung Disease Depression Diabetes End Stage Kidney Disease High blood pressure HIV/AIDS
High Cholesterol Leukemia Lymphoma Colon Cancer Anxiety Asthma Atrial Fibrillation Stroke
Coronary Artery Disease Hearing Loss Hyper or hypothyroidism Breast Cancer Lung Cancer Prostate Cancer
Transplantation surgery/Organ Transplant
Other:_____

Have you had any surgeries? (including joint replacement and heart valve surgeries):

Colectomy Coronary Artery Bypass Graft (CABG) Tubal Ligation Heart Valve Replacement Hysterectomy
Mastectomy Hip Replacement Knee Replacement Liver Transplant Heart Transplant Kidney Transplant

List any surgeries you have had:
_____
_____
_____

Do you have a history of any of the following skin conditions?

Acne Eczema Atypical Moles Actinic Keratosis Psoriasis Basal Cell Carcinoma
Melanoma Mole Removal Squamous Cell Carcinoma Sunburn
Skin Cancer Type and Location(s):_____

Do you have a family history of melanoma (a specific type of skin cancer)? Yes No What relative: _____

List all Medications/Supplements: (including over the counter)
_____
_____
_____

Drug Allergies:
_____
_____

Smoking Status: None Current Daily Smoker Current Some Day Smoker Former Smoker

Alcohol: None 1-3 drinks per week 3-5 drinks per week 6-10 drinks per week More than 2 drinks daily

Are you currently: Pregnant Yes No
Planning Pregnancy Yes No
Breast Feeding Yes No