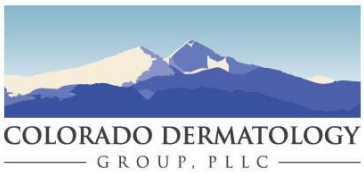

PATIENT INTAKE FORM Today's Date: _____

_____

Last Name First Name Nickname

Email _____ Do you wish to receive promotional emails? Yes / No

Address _____ City _____ State _____ Zip _____

Cell phone #_____ Home phone #_____ (*Please circle preferred*)

Date of Birth _____ Age _____ Sex _____ SSN # _____

Occupation_____ Employer _____

Race/Ethnicity _____ Preferred Language _____

In case of emergency, who should be notified? _____

Relationship _____ Phone _____

Do you give our office permission to discuss your medical information with family members, including biopsy results, lab results, office notes and other test results? Yes / No

Disclose to _____ Relationship_____

Do you authorize Colorado Dermatology Group, PLLC to leave a detailed voicemail with results? Yes / No

Preferred Pharmacy (Name, Location) _____

Primary Care Physician _____ **Referring Physician**_____

INSURANCE INFORMATION Please provide card(s) to receptionist*

SUBSCRIBER **If different from patient, please note who is responsible for the balance due.*

*Subscriber Name_____ SSN #_____

Relationship _____Date of Birth _____ Phone #_____

Address _____ City _____ State _____ Zip _____

HOW WERE YOU REFERRED TO US?

Physician | Friend | Relative | Prior Patient | Google | Insurance | Newspaper | Facebook | Special Event

Other_____

COLORADO DERMATOLOGY GROUP, PLLC

PATIENT HEALTH HISTORY FORM

Reason for Today's Visit_____

Have you received your flu vaccine this season? Yes / No

Have you received the pneumonia vaccine? *(if <2 years old, >65 years old, or immunosuppressed)* Yes / No

Have you been previously diagnosed with any of the following? Who is the doctor managing the issue?
Please indicate any medical problems not listed below in "Other".

Anxiety/ Depression Doctor:_____	COPD Doctor:_____	Heart Valve Replacement Doctor:_____	Hypothyroidism Doctor:_____
Arthritis Doctor:_____	Coronary Heart Disease Doctor:_____	Hepatitis Doctor:_____	Joint Replacement Doctor:_____
Asthma Doctor:_____	Diabetes Doctor:_____	High Blood Pressure Doctor:_____	Leukemia/Lymphoma Doctor:_____
Atrial Fibrillation Doctor:_____	End Stage Renal Disease Doctor:_____	High Cholesterol Doctor:_____	Organ Transplant Doctor:_____
BPH (Enlarged Prostate) Doctor:_____	GERD (Acid Reflux) Doctor:_____	HIV/AIDS Doctor:_____	Radiation Doctor:_____
Cancer type_____ Doctor:_____	Hearing Loss Doctor:_____	Hyperthyroidism Doctor:_____	Stroke Doctor:_____

Other_____

PAST SURGICAL HISTORY *Please state year performed. May use back of packet if needed to list additional surgeries.*

1.	2.

SKIN DISEASE HISTORY

Melanoma If so: Date of last eye exam _____ Date of last dental exam _____ Date of last pelvic exam _____	Basal Cell Carcinoma	Squamous Cell Carcinoma
Acne	Actinic Keratosis	Allergic rashes
Blistering Sunburn	Dry Skin	Eczema
Flaky/ Itchy Scalp	Precancerous or Atypical Moles	Psoriasis

Other_____

Do you use sunscreen?	Yes	No	If Yes, what SPF?
Do you use a tanning bed?	Never	Former	Current

COLORADO DERMATOLOGY
GROUP, PLLC

MEDICATIONS

List all medications you are currently taking (including prescriptions, over-the-counter, vitamins, and herbals):
Include dose and frequency if known. Please use other side if needed to list additional medications.

1.	4.
2.	5.
3.	6.

Medication Allergies _____

SOCIAL AND FAMILY HISTORY

Do you smoke?	Never	Former	Current	If Yes, how much per day?
Do you drink alcohol?		Yes	No	If Yes, how many drinks per day?
Has anyone in your family had Melanoma?		Yes	No	If Yes, who?
Has anyone in your family had atypical moles?		Yes	No	If Yes, who and what?
Has anyone in your family had other types of skin cancer?		Yes	No	If Yes, who and what?

REVIEW OF SYSTEMS/ ALERTS

Do you bleed easily?	Yes	No	If yes, are you on blood thinners?		
Do you develop keloid scars? (firm thick scars)	Yes	No			
Do you develop rashes or reactions to bandages?	Yes	No			
Do you have an Artificial Heart Valve?	Yes	No			
Have you had Artificial Joints within the last 2 years?	Yes	No	If Yes, date of surgery _____		
Do you have a Defibrillator or Pacemaker?	Yes	No			
Do you have a history of MRSA?	Yes	No			
Do you require antibiotics prior to procedures?	Yes	No			
Do you get a rapid heartbeat with epinepherine?	Yes	No			
If applicable, are you pregnant?	Yes	No	Breastfeeding?	Yes	No