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

Email Address: _____

OK to (circle one): Leave voice message? Yes No Text? Yes No Email health info? Yes No

Emergency Contact:_____Relationship:_____Phone #:_____

If patient is a minor, please list all parent/guardian names and phone numbers:_____

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

Women: How many times in the last year have you had 4 or more drinks in a day? 0 1 >1
Men: How many times in the last year have you had 5 or more drinks in a day? 0 1 >1

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