Alaska Center for Dermatology, P. C.

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Dermatology Intake Form

Patient Name_____**Date of Birth**_____

Occupation_____ **Preferred Pharmacy & Location**_____

Who is your primary care provider? (MD, NP, PA-C, etc) _____

Were you referred for this appointment? ☐ Yes ☐ No **If so, by whom?** _____

Medication/Allergies

Do you take any prescription or non-prescription medication? If yes, list with dosage. ☐ Yes ☐ No

_____

Please list all allergies to medication: ☐ No Known Drug Allergies

_____

Skin	Yes	No	
Do you have a personal history of melanoma?	☐	☐	
Have you ever had skin cancer?	☐	☐	If Yes, what type? _____
Has anyone in your family had skin cancer?	☐	☐	If Yes, what type? _____
Do you have a history of any specific skin diseases?	☐	☐	If Yes, please list: _____
Do you have problems with healing?	☐	☐	
Do you develop keloids after surgery?	☐	☐	
Do you bleed easily?	☐	☐	

Do you develop skin rashes in reaction to ☐ Medications? ☐ Food? ☐ Environment?

If Yes, please explain: _____

Medical History

Do you currently have or have you ever had:

☐ Asthma ☐ COPD ☐ Tuberculosis ☐ High blood pressure ☐ Heart attack ☐ Afib ☐ Stroke

☐ Diabetes ☐ Arthritis ☐ Hyperthyroid ☐ Hypothyroid ☐ Artificial Joints ☐ Hepatitis B/C ☐ HIV/AIDS

History of Cancer? ☐ Yes ☐ No If Yes, what type and where: _____

If Yes, what was your treatment:_____

Do you have a pacemaker? ☐ Yes ☐ No If Yes, does it have a defibrillator? ☐ Yes ☐ No

List any surgeries you have had in the last six months: _____

Ethnicity: ☐ Non-Hispanic ☐ Hispanic ☐ Prefer not to answer **Preferred Language**:_____

Race: ☐ Caucasian or European American ☐ African American ☐ Asian or Asian American

☐ Native Alaskan or Native American ☐ Native Hawaiian or Other Pacific Islander ☐ Prefer not to answer

Smoking Status:

☐ Never smoked

☐ Current every day smoker

☐ Current some day smoker

☐ Former smoker

Women:

Are you pregnant or trying to conceive? ☐ Yes ☐ No

If you are currently pregnant, what is your due date? _____

Are you currently breastfeeding? ☐ Yes ☐ No

Signature _____**Date**_____

(Patient, Or Guardian if Minor)