MARIETTA DERMATOLOGY & THE SKIN CANCER CENTER

PATIENT INTAKE FORM

Patient Name: _____ D.O.B: _____Today's Date:_____

PAST MEDICAL HISTORY:

Personal history of cancer other than skin?_____

__Anxiety	__COPD	__High Blood Pressure	__Thyroid Issues
__Arthritis	__ Depression	__Inflammatory Bowel Disease	__Radiation Treatment
__Asthma	__ Diabetes	__Organ Transplant, Type:_____	__Stroke
__Eczema	__Psoriasis	__Hay Fever	__Heart Disease

Other Medical History not listed**:**_____

HISTORY OF SKIN DISEASE:

Personal History of Skin Cancer? __Basal Cell Carcinoma __Squamous Cell Carcinoma __Melanoma

DO YOU HAVE A FAMILY HISTORY OF MELANOMA? Relative (s):_____

MEDICATION: Check here if you have an attached list _____

Please include dosage and strength if known_____

_____

_____

Patient Height: _____ Patient Weight: _____ (Required for prescriptions)

ALLERGIES: _____

SOCIAL HISTORY: Do you smoke? __Yes __No **Do you drink alcohol? __Yes __No**

Number of packs per day ____ **Number of drinks per week? _____**

ALERTS:

__Allergy to Adhesive	__On Blood Thinners/Aspirin	__MRSA
__Allergy to Lidocaine	__History of Fever Blisters	__Seizures
__Allergy to Latex	__Pacemaker	__Kidney disease
__Allergy to Iodine	__Defibrillator	__C-Diff
__Artificial Joint	__HIV/AIDS	__Pregnant or trying to get pregnant
__Artificial Heart Valve	__Hepatitis B	__Breast Feeding
__Allergy to Oral Antibiotics	__Hepatitis C	__Neurostimulator/implantable device
__Requires Antibiotics prior to procedure	__Rapid Heartbeat with epinephrine	

PREFERRED PHARMACY:

Pharmacy Name:_____ Pharmacy Number:_____

Pharmacy Address:_____

PCP:_____ Referring Provider:_____

I AUTHORIZE MARIETTA DERMATOLOGY & THE SKIN CANCER CENTER TO RETRIEVE MY MEDICATION HISTORY THROUGH THEIR PRESCRIBING SYSTEM AND IMPORT IT INTO MY ELECTRONIC MEDICAL RECORD

SIGNATURE:_____ DATE:_____

Updated: October 2020