

Acclaim Dermatology Intake Form

**Patient Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Nickname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_**

**Height: \_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_ If a minor, Parents Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Birth Sex: \_\_\_\_\_\_\_\_\_ Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_
*If we need to contact you M-F, 8-5, what is the best way to reach you?*** (Please circle one below)

**Phone Numbers: Home: Cell: Work: l**

**Email: Other: I**

**In Case of Emergency:**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relation to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Preferred Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Alerts:** (Please Check Yes or No)

\_\_\_Y \_\_\_ N Artificial Heart Valve or Joints

\_\_\_Y \_\_\_ N Pacemaker or Defibrillator Present

\_\_\_Y \_\_\_ N Rapid Heartbeat with Epinephrine

\_\_\_Y \_\_\_ N Blood Thinners

\_\_\_Y \_\_\_ N Premedication Prior to Procedures

**\*\*\*Women Only:**

Pregnant, planning a pregnancy or breast feeding \_\_\_ Y \_\_\_ N

Last Menstrual Period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Medical History:** (Please Check All That Apply, If None Check **NONE**)

**\_\_\_ NONE**

\_\_\_ Anxiety

\_\_\_ Arthritis

\_\_\_ Asthma

­\_\_\_ Atrial Fibrillation

­­\_\_\_ Noncancerous Prostate Enlargement

\_\_\_ Cerebrovascular accident

\_\_\_ COPD

\_\_\_ Coronary artery disease

\_\_\_ Depression

\_\_\_ Diabetes Mellitus

\_\_\_ Disease caused by Covid- 19

\_\_\_ High Blood Pressure

\_\_\_ End-Stage Renal Disease

\_\_\_ Epilepsy

\_\_\_ GERD

\_\_\_ Hearing Loss

\_\_\_ HIV/AIDS

\_\_\_ High Cholesterol

\_\_\_ Hyperthyroidism

\_\_\_ Hypothyroidism

\_\_\_ Hepatitis

\_\_\_ Leukemia

\_\_\_ Lupus

\_\_\_ Malignant Lymphoma

\_\_\_ Breast Cancer

\_\_\_ Colon Cancer

\_\_\_ Lung Cancer

­­\_\_\_ Prostate Cancer

\_\_\_ Radiation Therapy Treatment

\_\_\_ Bone Marrow Transplant

**Other:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Surgical History:** (Please Check All That Apply, If None Check **NONE**)

**\_\_\_ NONE**

\_\_\_ Removal of Anal or Rectal Cancer

\_\_\_ Bilateral Knee Joint Replacement

\_\_\_ Breast Biopsy

\_\_\_ Prostate Biopsy

\_\_\_ Coronary Artery Bypass Graft

\_\_\_ Kidney Transplant

\_\_\_ Excision of Basal Cell Carcinoma

\_\_\_ Excision of melanoma

\_\_\_ Excision of squamous cell carcinoma

\_\_\_ Bowel Procedure

\_\_\_ Tubal Litigation

\_\_\_ Appendectomy

\_\_\_ Bilateral Breast Mastectomy

\_\_\_ Gallbladder Removed

\_\_\_ Liver Excision

\_\_\_ Tissue Graft Heart Valve Replacement

\_\_\_ Urinary Bladder Removed

\_\_\_ Prostatectomy

\_\_\_ Hysterectomy

\_\_\_ Kidney Biopsy

\_\_\_ Mechanical Heart Valve Replacement

\_\_\_ One or Both Ovaries Removed

\_\_\_ Pancreas Removed

\_\_\_ Kidney Stone(s) Removed

\_\_\_ Portosystemic Shunt Operation

\_\_\_ Spleen Removed

\_\_\_ Skin Biopsy

\_\_\_ Kidney Removed

\_\_\_ Heart Transplant

\_\_\_ Liver Transplant

**Other:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Skin Disease History:** (Please Check All That Apply, If None Check **NONE**)

\_\_\_ **NONE**

\_\_\_ Acne

\_\_\_ Actinic Keratosis

\_\_\_ Dry/Scaly Skin

\_\_\_ Basal Cell Carcinoma

\_\_\_ Dermatitis from Poison Ivy

\_\_\_ Atypical Moles

\_\_\_ Eczema

\_\_\_ Asthma

\_\_\_ Hay Fever

\_\_\_ Malignant Melanoma

\_\_\_ Flaking or Itchy Scalp

\_\_\_ Psoriasis

\_\_\_ Squamous Cell Carcinoma

\_\_\_ Second Degree Sunburn

**Other:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Do you wear Sunscreen?** \_\_\_ Y \_\_\_ N *If yes, what SPF? \_\_\_\_\_*

**Do you tan in a tanning salon?** \_\_\_ Y \_\_\_ N

**Do you have a family history of Melanoma?** \_\_\_ Y \_\_\_ N

If yes, which relative(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Any Other Family History:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Medications:**

Are you taking any medications (prescriptions, over-the-counter) regularly now? \_\_\_ Y \_\_\_ N

If yes, please print all current medications and dosages below

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication Allergies:** \_\_\_ Y \_\_\_ N

If yes, please print all medication allergies and include reaction below

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other Allergies:** \_\_\_Y \_\_\_N

If yes, please print all allergies and include reaction below

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History:** (Please Check All That Apply)

**Cigarette Smoking:**

\_\_\_ Never \_\_\_ Former Smoker \_\_\_ Smokes Daily

How Much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Alcohol Use:**

\_\_\_ Never \_\_\_ Social \_\_\_ Heavy

How Much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Illicit Drug Use:**

\_\_\_ Never \_\_\_ Drug Use \_\_\_ IV Drug Use

**The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize
Acclaim Dermatology or insurance company to release any information required to process my claims.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Print Patient Name**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature (or guardian)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship**