Medication	Dose	Frequency	Medication	Dose	Frequency
1.			7.		
2.			8.		
3.			9.		
4.			10.		
5.			11.		
6.			12.		

Allergies: (Please enter all allergies and associated reactions)

_____

_____

Social History: Currently smokes, **daily** Currently smokes, **not daily** **Never** smoked **Former** smoker

Height_____ Weight_____

Do you have a Living Will? Yes No

Alcohol: Men: How many times in the past year have you had five (5) or more drinks in a day? _____

Women: How many times in the past year have you had four (4) or more drinks a day? _____

Drug Use: None _____ Other_____

Have you had a flu vaccine within the past year?__Yes ___ No **Have you had the pneumonia vaccine?** ___Yes ___No

History of Melanoma	Yes	No	Pregnancy/planning pregnancy	Yes	No
Pacemaker	Yes	No	Breastfeeding/lactation	Yes	No
Defibrillator	Yes	No	Rapid heart beat with epinephrine	Yes	No
Artificial joints last 2 years	Yes	No	Allergy to lidocaine	Yes	No
Artificial heart valve	Yes	No	Problems with bleeding	Yes	No
Premedication prior to procedure	Yes	No	Problems with healing	Yes	No
Allergy to adhesive	Yes	No	Problems with scarring (hypertrophic/keloid)	Yes	No
Allergy to topical antibiotic ointment	Yes	No	Immunosuppression	Yes	No
Blood thinners	Yes	No	Botox/Dysport	Yes	No
Dermal Fillers (Restylane/Juvederm)	Yes	No	Cosmetic Surgery _____	Yes	No

Are you interested in the following: (Please circle all that apply)

Removal of unwanted hair	Wrinkle improvement	Sun or age spots	Skin Tightening
Body image	Redness reduction	Spider veins	Overall skin concerns
Sagging jowls	Large pores	Acne scars	Double chin

May we contact you about the above services? Yes_____ No_____

How did you hear about us? (Please circle all that apply) Google Social media Friend Family Physician

Pharmacy Name: _____

Pharmacy Telephone:_____ Fax: _____

Street _____City_____Zip Code

Referring Physician: _____

Telephone: _____ Fax:_____

Street _____City_____Zip Code

Family/Primary Physician: _____ **Date of Last Visit**:_____

Telephone_____Fax:_____

Street_____City_____Zip Code_____

DERMATOLOGY ASSOCIATES OF PLYMOUTH MEETING, P.C.

Dermatology, Dermatologic Surgery, Mohs Surgery, Pathology

Intake Form

Patient: _____Phone Number: _____DOB:_____

State of Birth:_____Today's Date:_____

Reason for today's visit: _____

Current Medical History: (Please circle all that apply)

Anxiety	COPD	Hepatitis	Lymphoma
Arthritis	Coronary Artery Disease	High blood pressure	Pacemaker
Asthma	Depression	HIV/AIDS	Prostate Cancer
Atrial fibrillation	Diabetes	High cholesterol	Radiation Treatment
BPH	End Stage Renal Disease	Hyperthyroidism	Seizures
Bone Marrow Transplantation	GERD	Hypothyroidism	Stroke
Breast Cancer	Leukemia	Valve Replacement	
Colon Cancer	Hearing Loss	Lung Cancer	None

Other_____

Past Surgical History: (Please circle all that apply)

Appendix removed	Coronary Artery Bypass	Ovaries Removed Endometriosis
Bladder Removed	PTCA (Percutaneous transluminal coronary angioplasty	Ovaries Removed Cyst
Mastectomy (Right, Left, Bilateral)	Mechanical Valve Replacement	Ovaries Removed Ovarian Cancer
Lumpectomy (Right, Left, Bilateral)	Joint Replacement Knee, (Right, Left, Bilateral)	Prostate Removed Prostate Cancer
Breast Biopsy (Right, Left, Bilateral)l	Joint Replacement Hip (Right, Left, Bilateral)	Prostate Biopsy
Breast Reduction	Hysterectomy: Fibroids	TURP
Breast Implants	Hysterectomy: Uterine Cancer	Spleen Removed
Colectomy: Colon Cancer Resection	Kidney Biopsy	Testicles Removed
Colectomy: Diverticulitis	Kidney Removed (Right, Left)	(Right, Left, Bilateral)
Colectomy: IBS	Kidney Stone Removal	None
Gallbladder Removed	Kidney Transplant	

Other _____

Skin Disease History: (Please circle all that apply)

Acne	Eczema	Squamous Cell Skin Cancer
Actinic keratosis	Flaking or Itchy Scalp	None
Basal Cell Carcinoma	Melanoma	Hay Fever/Allergies
Blistering Sunburns	Precancerous Moles	
Dry Skin	Psoriasis	

Other_____

Do **you** have a history of Melanoma? Yes No
Do you have a **family** history of Melanoma? Yes No
If so, which relative(s)?_____

Do you tan in a salon? Yes No

Do you wear Sunscreen: Yes No
If yes, what SPF? _____