San Antonio Skin and Cancer Clinic

New patient intake form

Patient name:_____ DOB: _____

What brings you in today?_____

Past Medical History: (please circle all that apply)

Anxiety	Depression	Leukemia
Arthritis	Diabetes	Lung Cancer
Asthma	Heart disease	Lymphoma
Atrial fibrillation	Hepatitis	Prostate Cancer
Bone thinning	High Blood pressure	Radiation Treatment
Breast Cancer	HIV/AIDS	Seizures
Colon Cancer	Kidney disease	Stroke
COPD	Thyroid problems	Transplant
		NONE

Other _____

ALERTS: (please circle all that apply)
Are you pregnant, breastfeeding or currently trying to get pregnant?
Allergy to lidocaine
Allergy to topical antibiotics
Artificial heart valve
Artificial joint replacement
Blood thinners (aspirin, warfarin, plavix)
Defibrillator /Pacemaker
Require antibiotics prior to a surgical procedure
Rapid heart beat with epinephrine

Past Surgical History: Have you had any surgeries? Please list if so:

Skin Disease History: (please circle all that apply)

Acne	Eczema	Psoriasis
Blistering sunburns	Flaking or Itchy Scalp	Sensitive skin
Cancer	Hay Fever/Allergies	
Dry skin	Precancerous Moles	NONE

Do you have a FAMILY history of :

Skin Cancer? Yes No If yes, which relative?_____
Diabetes? Yes No If yes, which relative?_____
High blood pressure? Yes No If yes, which relative?_____

Medications: (Please enter all current medications)

_____
_____
_____

Allergies: (Please enter all allergies)

_____
_____

Cigarette Smoking: **Yes** **No** **Alcohol Use:** **Yes** **No**
Have you ever smoked? **Yes** **No**

Current illegal drug use: **Yes** **No**

Are you currently experiencing any of the following?

Symptom	Yes	No
Nausea		
Vomiting		
Bleeding problems		
Fever		
Joint pain		

Questions with " * " are optional and requested by some insurance companies:

*Preferred Language: _____ *Race:_____

*Ethnic Group:_____

Preferred pharmacy name, zip code and phone #:

_____

_____ _____
Patient signature Date