Skin & Laser Center of NJ

PATIENT HISTORY AND INTAKE FORM

Name: ______________________________ Date of Birth: ____________

Pharmacy name: ____________________ Pharmacy address: ______________________________

City: ________________ State: ________ Pharmacy Phone #: ______________ Ht: _____ Wt:_____

Preferred laboratory: ____________________ City: ______________________ State: ____________

What is the primary problem that brings you to the office today? ______________________________

How long have you had this problem? ______________________________

Have you been treated by another doctor for this problem? If yes, who? ______________________________

Allergies to medications: (Write NONE if none, please enter all known allergies AND the reaction)

____

____

Prescription medications: (Write NONE if none; enter all current medications; use back of page if more space is needed, or attach list)

____

____

____

Over-the-counter medications: (vitamins, herbs, minerals, supplements)

____

____

Topical skin medications / creams: (prescription and over-the-counter)

____

____

Did you receive the pneumonia vaccine? NO YES Did you receive the shingles vaccine? NO YES

Did you receive the flu vaccine this year? NO YES → If so, please write the month and year (flu) _____

Family Skin Disease History (circle all that apply)

Actinic keratosis (pre-cancer) ____________	Allergies/Asthma ____________
Abnormal moles ____________	Eczema ____________
Basal cell skin cancer (who) ____________	Lupus ____________
Squamous cell skin cancer (who) ____________	Psoriasis ____________
Melanoma (who) ____________	OTHER ____________

Social History (circle answers)

Sun exposure:	Minimal	Tanning salons	NO YES IN THE PAST
	Occasional	Sunscreen routinely	NO YES
	Moderate	Number of children	____________
	Frequently	Occupation	____________
Smoking:	Current smoker – daily	**Alcohol history:**	None/Never
	Social smoker – not daily		Occasional
	Former smoker		Moderate
	Never smoker		Heavy
# years smoked	_______	**E-cigarette / Vaping**	NO YES **# of years** _______

Name: ______________________________ Date of Birth: ____________________

Past Surgical History (circle all that apply to you, **indicate the year it was performed**, provide details):

Appendix removal ______________	Mastectomy (left or right) ______________
Angioplasty/heart stent placement ______________	Joint replacement ______________
Bladder removal ______________	Organ transplantation ______________
Cardiac surgery ______________	Skin lesion removal surgery______________
Cosmetic surgery ______________	Valve replacement ______________
Hysterectomy ______________	OTHER______________

Gynecologic History (**FEMALES** circle all that apply to you, **indicate the year it was performed**, provide details):

Do you have regular periods	NO YES	Do you take birth control pills	NO YES
Are you breastfeeding?	NO YES	Are you trying to get pregnant?	NO YES
Do you have excessive hair growth?	NO YES	Have you gone through menopause?	NO YES

Past Medical History (circle all that apply to you, and give details):

Anxiety ______________	GERD/heartburn______________	Radiation treatments ______________
Arthritis ______________	High blood pressure______________	Rheumatologic illness ______________
Allergies/Asthma ______________	High cholesterol ______________	Seizures ______________
Atrial fibrillation ______________	Kidney disease ______________	Stroke______________
Cancer (type) ______________	Liver disease ______________	Thyroid disease ______________
Treatment/Year______________	Low blood pressure ______________	**FEMALES:**
Cardiac/heart disease ______________	Lung disease ______________	Pregnancy ______________
Chicken Pox______________	Lupus ______________	Irregular periods ______________
COPD/Emphysema______________	Psychiatric illness ______________	Excessive hair growth ______________
Depression ______________	Radiation treatments______________	Menopause ______________
Diabetes______________	OTHER ______________	

Skin Disease History (circle all that apply to you)

Acne ______________	Psoriasis ______________
Actinic keratosis (pre-cancer) ______________	Eczema______________
Asthma/allergies______________	Lupus______________
Abnormal mole ______________	Sunburns in the past ______________
Cosmetic procedures ______________	Tanning salons (now or in the past) ______________

Basal cell skin cancer (provide year and treatment done)______________

Squamous cell skin cancer (provide year and treatment done)______________

Melanoma (provide year and treatment done) ______________

Do you wear sunscreen? NO YES SPF:__________ Other skin history ______________

I attest that all information provided on this form is true to my knowledge.

X ______________________________ Date: ______________

(Patient signature; if minor then parent/guardian must sign)