azeal
DERMATOLOGY INSTITUTE

Medical Dermatology Intake

Name: DOB: Social Security #:

Address:

City: State: Zip:

E-mail Address: Phone Number: ☐ Ok to leave a message?

Employer: How did you hear about us?

Emergency Contact Name: Phone Number: Relationship:

Primary Doctor: Send Your Doctor a Copy of Today's Visit? Yes/No

What brings you into the office today? _____

Concerns with your skin/body: (check all that apply)

- ○ Dry Skin
- ○ Acne
- ○ Oily Skin
- ○ Uneven Skin Tone
- ○ Large Pores
- ○ Rosacea
- ○ Broken Capillaries
- ○ Sun Damage
- ○ Fine Lines
- ○ Deeper Wrinkles
- ○ Sweating or Underarm Odor
- ○ Unwanted Hair
- ○ Coarse Hair
- ○ Brown spots
- ○ Discoloration
- ○ Other_____

Services you are interested in: (check all that apply)

- ○ Facial
- ○ Dermaplaning
- ○ Chemical Peels
- ○ Hydrafacial treatment
- ○ Microneedling
- ○ Body Contouring
- ○ Hair removal (list areas):
  - ○ _____
- ○ Sunscreen
- ○ Skin Care Products
- ○ Make-up consultation
- ○ Botox
- ○ Fillers
- ○ Laser Treatment
- ○ Laser Resurfacing
- ○ Laser to eliminate sweating & odor

Have you received Neuromodulators (Botox) or Dermal Fillers? No/Yes (if yes, date of last injection): _____

Medical History: (Please circle all that apply) NONE

Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
High Blood pressure
HIV/AIDS
High Cholesterol
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke

Other:
_____

Past Surgical History: (please circle all that apply) NONE

Appendix Removed
Bladder Removed
Mastectomy (Right, Left)
Lumpectomy (Right, Left)
Breast Biopsy (Right, Left)
Breast Reduction
Breast Implants
Colectomy: Reason_____
Gallbladder Removed
Coronary Artery Bypass
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left)
Joint Replacement, Hip (Right, Left)
Joint Replacement w/in last 2 yrs
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Reason_____
Prostate Removed: Reason _____
Prostate Biopsy
TURP (Prostate Removal)
Spleen Removed
Testicles Removed (Right, Left)
Hysterectomy: Reason _____

Other:_____

Skin Disease History: (please circle all that apply) NONE

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer

Other:_____

Do you wear Sunscreen? Yes No If yes, what SPF? _____ Do you tan in a tanning salon? Yes No

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

Medications: (Please enter all current medications)

_____
_____
_____

Please list all products used in your skin care regimen: _____
_____
_____

Allergies: (Please enter all allergies)

_____
_____
_____

Social History: (Please circle all that apply)

Cigarette Smoking:
Currently Smokes
Never smoked
Former Smoker
Other: _____

Alcohol Use:
No Alcohol intake
Less than 1 drink per day
1-2 drinks per day
3 or more drinks per day

Family History: Please list any medical conditions of your first-degree relatives (list which relative)

_____

_____

Preferred Language: _____Race:_____ Ethnic Group:_____

Preferred Pharmacy Name: _____Phone#: _____

City or Zip code:_____

Review of Systems: Are you currently experiencing any of the following? (Please check yes or no for the following)

Symptom:	Yes	No
Problems with bleeding		
Problems with healing		
Problems with scarring (hypertrophic scarring or keloid)		
Rash		
Immunosuppression		
Chest Pain		
Fever or chills		
Night Sweats		
Unintentional weight loss		
Thyroid problems		
Sore throat		
Blurry vision		
Abdominal pain		
Bloody urine		
Joint aches		
Muscle weakness		
Headaches		
Seizures		
Cough		
Shortness of breath		
Wheezing		
Anxiety		
Depression		

Other Symptoms: _____

ALERTS: (please circle all that apply)

Allergy to Adhesive
Allergy to lidocaine
Allergy to topical antibiotics
Artificial heart valve
Artificial joint replacement
Other: _____

Blood thinners
Defibrillator
MRSA
Pacemaker
Require antibiotics prior to a surgical procedure
Rapid heart beat with epinephrine
Are you pregnant or currently trying to get pregnant?

- **I authorize Azeal Dermatology to send promotional and educational materials to the e-mail address provided above.**