Arsenault DERMATOLOGY

Name: _____

Date of Birth: _____

Today's Date: _____

Clinical Intake (Page 2 of 2)

Allergies

Please list all allergies to medications and the reaction you have (if none write **NONE**):

Review of Systems

Yes	No	
☐	☐	Problems with bleeding
☐	☐	Problems with healing
☐	☐	Problems with scarring
☐	☐	Problems with your immune system
☐	☐	Take medications that lower your
☐	☐	immune system
☐	☐	Do you faint with procedures?
☐	☐	Allergy to lidocaine
☐	☐	Rapid hearbeat with epinephrine
☐	☐	Allergy to adhesive
☐	☐	Allergy to latex
☐	☐	Allergy to topical antibiotic ointments
☐	☐	Artificial heart valve
☐	☐	Artifical joints w/in the past 2 years
☐	☐	Blood thinners
☐	☐	Pacemaker
☐	☐	Debibrillator
☐	☐	History of MRSA
☐	☐	HIV/AIDS
☐	☐	Hepatitis
☐	☐	Premedicate prior to a procedure
☐	☐	Pregnant or trying to become pregnant
☐	☐	Breastfeeding

Social History

Check all that apply to you:

- ☐ **Never smoked**
- ☐ **Former smoker**
- ☐ **Current smoker**

Please answer the following if you are 65 years of age or older:

Check all that apply to you:

- ☐ **Living will**
- ☐ **Health care proxy**
- ☐ **None**

Provide copies of legal documents to our team.

Health care proxy name & contact number:

_____

Which statement best reflects your wishes on advance care recommendations? **(select one)**

- ☐ **Full Code:** *I wish to have full cardiopulmonary resuscitation efforts to be made.*
- ☐ **Do Not Intubate:** *I do NOT wish to have a breathing tube, even if it is required for life saving measures.*
- ☐ **Do Not Resuscitate:** *In the event that my heart was to stop, I do NOT wish to have chest compressions or an automated external debibrillator to restart my heart, even if it is required for living saving measures.*

Arsenault DERMATOLOGY

Name: _____

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Clinical Intake (Page 1 of 2)

Pharmacy Name: Pharmacy Location:

Past Medical History

Yes	No	
☐	☐	Autoimmune disease
		if yes, what kind: _____
☐	☐	Bowel / stomach disease
		if yes, what kind: _____
☐	☐	Internal cancer
		if yes, what kind: _____
☐	☐	Genital disease
		if yes, what kind: _____
☐	☐	Heart attack
☐	☐	Infectious disease
		if yes, what kind: _____
☐	☐	Kidney disease
		if yes, what kind: _____
☐	☐	Liver disease
		if yes, what kind: _____
☐	☐	Lung disease
		if yes, what kind: _____
☐	☐	Seizures
☐	☐	Do you have a stent?
☐	☐	Stroke

Skin Disease History

Yes	No	
☐	☐	Abnormal moles
☐	☐	Actinic keratosis
☐	☐	Atopic dermatitis
☐	☐	Basal cell carcinoma
☐	☐	Eczema
☐	☐	History of severe sun burns
☐	☐	History of tanning bed use
☐	☐	Psoriasis
☐	☐	Squamous cell carcinoma
☐	☐	Melanoma
		if yes, what year? _____
☐	☐	*Lymph nodes removed?* _____

Family Melanoma History

Yes	No	
☐	☐	I have a FAMILY HISTORY of melanoma

if yes, please check all that apply:

- ☐ Parent
- ☐ Sibling
- ☐ Child

Current Medications

Name	Strength	Times / Day	Name	Strength	Times / Day
1.			5.		
2.			6.		
3.			7.		
4.			8.		

Arsenault DERMATOLOGY

New Patient Welcome Packet / Established Patient Annual Update

Demographics

Name:

Date of Birth:

Address:

Email:

Preferred Phone #:

Emergency Contact

Please let us know if you would like us to discuss your health care with anyone else:

First Name	Last Name	Relationship	Phone Number

Communications

We protect your privacy by using advanced software. **You will receive the best service by allowing text messages.** We **NEVER** sell patient data to 3rd party marketing companies.

We have permission to:

	Yes	No
Leave a voicemail	☐	☐
Send email notifications	☐	☐
Send text reminders and results	☐	☐

Note:
HIPAA requires us to inform you that all patients accept responsibility associated with protecting their own voice, email, and text notifications.

I acknowledge all of the above information is correct:

Patient or Legal Guardian Signature