Dermatology
UNIVERSITY OF COLORADO | BOULDER, CO

Date: _____

Welcome to Our Practice

Last Name: _____First Name: _____ MI: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Alternate #: _____ May we leave a message? ☐ Y ☐N

Social Security #: _____- ___- _____ Sex: ☐ Female ☐ Male ☐ Other

Date of Birth: ____ /_____ / _____ Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employer: _____ Occupation: _____

E-Mail: _____ Would you like to receive email promos and newsletters: Y ☐N ☐

Primary Care Physician: _____Phone #: _____

Referring Physician: _____Phone #: _____

Preferred Pharmacy (Please list phone number and cross streets): _____

Additional Parties Authorized to View Your Records

Name:_____Address:_____Phone#:_____

Name:_____Address:_____Phone#:_____

Someone to Contact in Case of Emergency

Name: _____ Relationship to Patient: _____ Home #: _____ Alt #: _____

Responsible Party: THE PERSON WHO SHOULD RECEIVE THE BILL

Relationship to Responsible party: ☐Self ☐ Spouse ☐ Son ☐ Daughter ☐Other

Name: _____ Date of Birth: _____ /_____/_____ Employer: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Alternate #: _____

Primary Insurance: _____

Address:_____

City/State/Zip:_____

Insured Name and DOB:_____

ID/Policy #:_____Suffix: _____

Group #:_____Employer: _____

Secondary Insurance: _____

Address: _____

City/State/Zip: _____y

Insured Name and DOB: _____

ID/Policy #: _____ Suffix: _____

Group#: _____ Employer: _____

I acknowledge that the above information is true: _____ _____

Patient signature **Date**

Name: _____

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Medical History

Reason for Today's Visit: _____

Skin Disease Conditions

Please Check all conditions that apply

□ Acne	□ Actinic Keratosis	□ Basal Cell Skin Cancer
□ Blistering Sunburns	□ Oral Herpes (Cold sores)	□ Eczema
□ Flaking or Itchy Scalp	□ Melanoma	□ Poison Ivy
□ Atypical Moles	□ Psoriasis	□ Squamous Cell Skin Cancer

Medical Conditions Please check all conditions you currently have or have had in the past year

GENERAL
□ Recent Fever/Chills
□ Recent Weight Loss

EYES
□ Eye Pain

ENDOCRINE
□ Diabetes
□ Thyroid Disease

CARDIOVASULAR
□ Heart Disease
□ Shortness of Breath
□ High Blood Pressure
□ Low Blood Pressure
□ Irregular Pulse
□ Heart Murmur
□ Leg Swelling

INFECTIOUS DISEASE
□ HIV Positive
□ Hepatitis
□ AIDS

EAR, NOSE, THROAT AND MOUTH
□ Balance Disturbance
□ Vertigo/Spinning
□ Nosebleeds

RESPIRATORY
□ Asthma
□ Emphysema
□ Bronchitis

GASTROINTESTINAL
□ Liver Disease
□ Ulcers or Gastritis

GENITOURINARY
□ Uterine/Cervical Cancer
□ Prostate Cancer

BLOOD AND LYMPH
□ Anemia
□ Hemophilia
□ Bleeding Tendencies
□ Swollen Glands or Lymph nodes
□ Blood Transfusion

NEUROLOGICAL
□ Headache
□ Loss of Consciousness
□ Dizziness/Vertigo
□ Poor Balance/Frequent Falling
□ Seizures
□ Paralysis
□ Face Weakness
□ Facial Pain
□ Facial Spasm

PSYCHOLOGICAL
□ Anxiety
□ Depression

MUSCULOSCELETAL
□ Back Pain
□ Leg Pain
□ Leg Weakness
□ Neck Pain
□ Arm Weakness
□ Arthritis

Other: _____
_____
_____

Review of Systems

Please check all that currently apply:

General:	☐ Fatigue	☐ Unexpected weight changes	
Gastrointestinal:	☐ Diarrhea	☐ Nausea	☐ Vomiting
Musculoskeletal:	☐ Joint Pain	☐ Muscle Aches	
Neurologic:	☐ Dizziness	☐ Headache	
Reproductive:	☐ Pregnant	☐ Planning Pregnancy	☐ Breastfeeding

Signature:_____Date:_____/____/_____

Name: _____

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Family History

Do you have a family history of melanoma? ☐ Yes ☐ No
If yes, which relative(s)? _____
List all other pertinent health information about your family: _____
_____
_____

Medications

List all medications and supplements you are currently taking: _____
_____
_____
Do you require antibiotics prior to surgery? Yes No

Allergies

List any known allergies and coinciding reactions, please include preparations or items used in office (example: latex gloves, Bacitracin, etc.): _____
_____

Hospitalizations/Surgeries

Please check all that apply: ☐ Heart Valve Replacement ☐ Joint Replacement ☐ Pacemaker/Defibrillator
List other surgeries/hospitalizations below:

Year	Hospital	Reason
_____	_____	_____
_____	_____	_____

Sun Exposure

Do you wear sunscreen? ☐ Yes ☐ No If yes, what SPF? _____
Do you avoid the sun? ☐ Yes ☐ No
Do you tan in a tanning salon? ☐ Yes ☐ No
Do you have a history of blistering sunburns? ☐ Yes ☐ No

Health Habits

Circle Yes or No and List Amount
Alcohol ☐Yes ☐No _____
Caffeine ☐Yes ☐No _____
Tobacco ☐Yes ☐No _____
Drugs ☐Yes ☐No _____

How were you referred to our office? Please list the source below.

□ Insurance Company Website: _____
□ Doctor: _____
□ Patient: _____
□ Other: (Example: Newspaper/Magazine Ad, Google, Yahoo, Dex Online, Yellow Pages):
_____

Is your illness or injury related to any of the following?

If work related, please describe circumstances:

□ Employment _____
□ Emergency _____
□ Accident _____
□ Other: _____

Ethnicity and Race

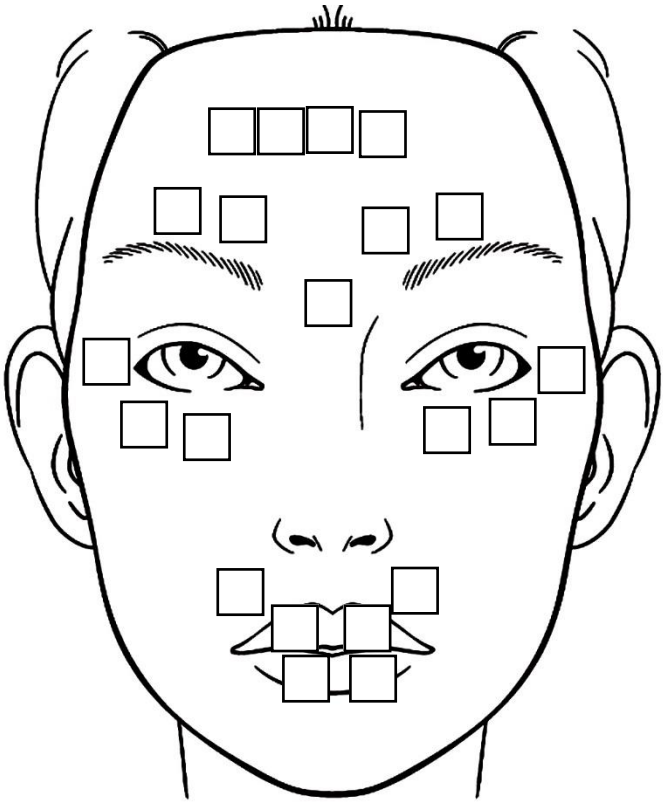
Which one of the following groups best represents your race? (Check only one) □ American Indian or Alaska Native □ Asian □ Native Hawaiian or Other Pacific Islander □ Black or African American □ White □ Hispanic □ Other Race
Are you of Hispanic or Latino Background? (check only one) □ Yes □ No □ Don't Know
What is your preferred language? _____

Signature: _____ Date: _____/____/_____

Name: _____

COSMETIC SERVICES

Please put an **x** on the areas of concern:



Please check the procedures you are interested in learning more about:

___ Botox/Dysport

___ Filler

___ Kybella

___ Photofacial

___ Profractional

___ Laser hair removal

___ Chemical Peel

___ Microdermabrasion

___ Dermaplaning

Signature:_____Date:_____/____/_____