TURNER DERMATOLOGY

Turner Dermatology History and Intake Form

Name:_____ Email:_____

Date of Birth: _____ Today's Date:_____

Past Medical History: (please circle all that apply)

Anxiety	Diabetes	Leukemia
Arthritis	Renal Disease	Lung Cancer
Asthma	GERD	Lymphoma
Atrial Fibrillation	Hearing Loss	Prostate Cancer
Breast Cancer	Hepatitis	Radiation Treatment
Colon Cancer	Hypertension	Seizures
COPD	HIV/AIDS	Stroke
Coronary Artery Disease		Implantable Devices (pacemaker, etc.)
Depression		Hypo/Hyperthyroidism

Past Surgical History: (please list all):

_____

_____

_____

Are you taking a blood thinner? _____

Skin Disease History (please circle all that apply):

Acne	Ezcema
Actinic Keratosis	Basal Cell Carcinoma
Melanoma	Blistering Sunburns
Psoriasis	Dysplastic Nevus (Pre-Cancerous Moles)
Squamous Cell Carcinoma	

Family History of Skin Cancer:

_____

_____

Do you wear sunscreen? **Yes / No**

Have you ever used a tanning salon? **Yes / No**

Is it okay to leave a detailed message on your voicemail regarding biopsy results? Yes / No
If yes, what phone number do you prefer: _____

I give permission for test results and information to be released to the following:

_____: Relationship_____
_____: Relationship_____

Medications: Please enter all current medications including over the counter and supplements, if too many to list, you can provide a written list.

_____
_____
_____
_____

Allergies:

_____
_____

Are you pregnant or nursing? Yes/No
Do you have an advanced directive? Yes / No
Have you had a flu/pneumonia vaccination this season? Yes / No

Cigarette Smoking:
Never Smoked
Former Smoker
Quit:_____
Active Smoker

Race:
White
Black/African American
Asian
American Indian or Native
Native Hawaiian/Pacific Islander

Pharmacy Information:
Name:_____
Zip Code:_____
Phone:_____

Primary Care:
Name:_____
Group:_____
Office Number:_____

I have read, understand, and will comply with the information within the following policies:

- Turner Dermatology 2018 Financial Policy
- Turner Dermatology 2018 Email Consent Policy
- Turner Dermatology Notice of Privacy Practices
- Turner Dermatology Patient and Family Rights and Responsibilities

_____

Patient Signature