University Skin Institute
Medical, Surgical, and Cosmetic Dermatology

650 University Avenue, Suite 200
Sacramento CA, 95825
Phone: (916) 571-5200
Fax: (916) 571-5099

New Patient Clinical Intake Form

Main reason for today's visit: ____

Qualities of your condition: ☐ Itching/flaking ☐ Pain/tenderness ☐ Burning/blistering

☐ Enlarging/Changing/Darkening ☐ No symptoms ☐ Other: _______________________________

Severity of your condition: ☐ Mild ☐ Moderate ☐ Severe

Duration of your condition: __________________________

Anything that makes your condition better/worse? Please explain: _____________________

Have you used any prescription medication for your condition? ______________________

Past Medical History: (please mark all that apply)

☐ Arthritis, Lupus, Autoimmune Disease

☐ Hepatitis B, Hepatitis C, HIV/Aids

☐ Blood transfusion, Bone Marrow, or Organ Transplant

☐ Anxiety, Depression, Eating Disorder, Psychological problems

☐ Asthma, Tuberculosis, COPD, Emphysema, Chest Disease

☐ Acid Reflux, GERD, Stomach Ulcers

☐ Faint Spells, Seizures, Stroke, Neurological Disease

☐ High or low blood pressure, High Cholesterol

☐ Heart Disease, Pacemaker, Valve Replacement, Atrial Fibrillation, Coronary Artery Disease

☐ Breast Cancer, Lung Cancer, Colon Cancer, Prostate Cancer, Leukemia, Lymphoma

☐ Radiation Treatment

☐ Diabetes, Thyroid Disease

☐ Liver Disease, Jaundice, Cirrhosis

☐ Artificial Joints

☐ Drug Abuse, Alcohol Abuse

☐ Kidney Disease, Prostatic Disease

☐ Migraines, Headaches, Chronic Pain

☐ Anemia, Blood/Bleeding Disease

☐ Other: _________________________________

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Have you had any surgeries in the past? (Please specify):

____

Any significant family history? ____

Skin Disease History: (Please mark all that apply)

☐ Acne, Acne Scarring

☐ Flaking, Itchy Scalp

☐ Dry Skin, Eczema

☐ Cold Sores/Fever Blisters/Oral Herpes/Genital Herpes

☐ Abnormal Moles

☐ Melanoma Skin Cancer

☐ Basal Cell Carcinoma or Squamous Cell Carcinoma

☐ Psoriasis

☐ Asthma/Hay Fever/Allergies

☐ Shingles

☐ Blistering Sunburns

☐ Actinc Keratoses

☐ Other Skin Disease: ___________________________

Do you wear sunscreen? Yes/No

Do you have a family history of Melanoma? No ____ Yes _____ Which relative? ____________________

When was your last full skin exam? ____

Medications (Please enter all current medications):

____

Allergies (Please enter all allergies and the type of reaction you had):

____

Social History:

Smoking: ☐ Never smoked ☐ Quit/Former Smoker ☐ Frequent smoker

Drinking: ☐ No alcohol ☐ Less than 1 drink per day ☐ 1-2 drinks per day

Review of Systems: Are you experiencing any of the following symptoms TODAY?

☐ Problems with healing or scarring (hypertrophic or keloid)

☐ Problems with bleeding

☐ Fever or chills

☐ Unintentional weight loss

☐ Immunosuppression

☐ Joint Aches

☐ Headaches

☐ Shortness of breath

☐ Chest Pain

☐ Abdominal Pain

☐ None

To help us provide you with the safest treatments, please mark all that apply:

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- Pregnant/breastfeeding or Planning a Pregnancy ☐Yes ☐ No
- History of MRSA/resistant staphylococcus infection ☐ Yes ☐ No
- History of or exposure to HIV infection ☐ Yes ☐ No
- History of or exposure to Hepatitis B or Hepatitis C ☐ Yes ☐ No
- Allergy to any of the following? ☐Adhesives ☐Lidocaine ☐Topical Antibiotics ☐None
- Do you get rapid heart-beat with epinephrine (eg. numbing, injections, etc)? ☐ Yes ☐No
- Do you have a defibrillator, pacemaker, artificial heart valve, or artificial joint placements? ☐ Yes ☐ No
- Are you required to take antibiotic premedication prior to surgical procedures? ☐ Yes ☐ No
- Are you on any blood thinners? ☐ Yes ☐ No

Are you interested in any of these services?

____ Skin Care Recommendations and/or Skin Care Products/Improvement of Complexion
____ Acne Scar Treatment
____ Peels (acne or rejuvenation)
____ Botox for prevention and treatment of facial wrinkles
____ Injectable fillers for prevention of treatment of facial folds and facial volume lines
____ Laser treatment for: ___ Wrinkles/Rejuvenation/Skin resurfacing
___ Sun Damage/burn ___ Facial Redness/Rosacea ___Brown/Red spots

Consent to Treatment:

I hereby consent to evaluation, testing, and medical treatment. I give permission to have a biopsy(s), minor surgical procedures, and any subsequent treatment as deemed necessary as long as the risks and complications are discussed with me prior to the procedure. I understand that no guarantee has been made to the results that may be obtained.

Print Name: ____ Relationship to Patient: ______________________

Patient Signature: ____ Date: _________________________