ALLURA SKIN & LASER CENTER, INC.
History and Intake Form

Patient Name: _____ **Date of birth:** _____

Past Medical History: (please circle all that apply) [ ] NONE

Anxiety	Depression	Hepatitis or liver disease	Tuberculosis
Arthritis	Diabetes	High cholesterol	Emphysema (COPD)
Artificial joints	Gastric reflux	High blood pressure	Radiation Treatment
Asthma	Glaucoma	Hyperthyroidism	Hypothyrodism
Hearing Loss	Heart attack	Heart murmur	Pacemaker
Heart arrhythmia	Heart Disease	Stroke	Seizures
Colon cancer	Breast cancer	Lung cancer	Prostate cancer
Leukemia/ lymphoma	AIDS/ HIV	Immunesuppression	Kidney Disease

Other_____

Past Surgical History: (please list) [ ] NONE

_____

_____

_____

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

Blistering Sunburns	Actinic Keratoses	Precancerous Moles
Keloids (Raised Scars)	Eczema	Psoriasis

Skin cancer (date and site) _____

_____

Melanoma (date and site) _____

Other_____

Do you wear Sunscreen? Yes No

If yes, what SPF? _____ Daily or as needed? _____

Do you tan in a tanning salon? Yes No

Medications: (Please enter all current medications)

Name:_____Dose_____Frequency_____

Name:_____Dose_____Frequency_____

Name:_____Dose_____Frequency_____

Name:_____Dose_____Frequency_____

Allergies: (please enter all allergies)

_____

_____

VACCINE HISTORY: Pneumonia Vaccine: Yes/No Date(If known):_____

Influenza Vaccine: Yes/No Date(If Known):_____

If not, do you have plans to get it soon: Yes/No

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Patient Name_____

ALERTS: (please circle all that apply)

Allergy to adhesive/ bandages
Allergy to lidocaine
Allergy to topical antibiotics
Artificial heart valve
Artificial joint replacement
Blood thinners
Allergy to latex
MRSA (history of staph infections)
Defibrillator/ Pacemaker
Require antibiotics prior to surgical procedure

Are you pregnant or currently trying to get pregnant? Yes No
Are you currently breastfeeding? Yes No

Social History: (Please circle all that apply)

Cigarette Smoking:

Currently Smokes
Has smoked in the past
Never Smoked
Former Smoker

Alcohol Use:

EtOH-None
EtOH-less than 1 drink per day
EtOH-1-2 drinks per day
EtOH-3 or more drinks per day

Family History: (only first degree relatives)

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____
Eczema
Psoriasis
Skin Cancer (basal cell carcinoma, squamous cell carcinoma)
Diabetes
Other:
_____
_____
_____

Preferred Language: _____ **Race:**_____

Preferred Method of Contact: Decline to receive reminders Patient Portal Phone
Email Letter Fax

Preferred pharmacy Name: _____

Pharmacy Phone#: _____

City or Zip code: _____