

**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	Hypothyroidism
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:** \_\_\_\_\_