Towne Centre
FOR DERMATOLOGY

HISTORY AND INTAKE FORM

Patient Name: _____ Today's Date: _____/_____/_____

Date of Birth: _____ Phone Number: (____) _____ - _____

Primary Care Physician: _____ Pharmacy Name & Location: _____

Email address : _____ Change of mailing address_____

I AM EXPERIENCING THE FOLLOWING (PLEASE CIRCLE ALL THAT APPLY):

- MALAISE (GENERAL FEELING OF BEING UNWELL)
- A RECENT INCREASE LEVEL OF STRESS
- PROBLEMS WITH BLEEDING
- PROBLEMS WITH HEALING
- PROBLEMS WITH SCARRING
- PROBLEMS WITH YOUR IMMUNE SYSTEM (IMMUNOSUPRESSION)
- FEVER
- JOINT PAIN
- NONE OF THE ABOVE

Tobacco/VAPE use (circle one):

Never Smoked / Current smoker/ Former smoker

I HAVE THE FOLLOWING (PLEASE CIRCLE ALL THAT APPLY):

- ALLERGY TO:
  - ADHESIVE
  - LIDOCAINE
  - TOPICAL ANTIBIOTICS
- BLOOD THINNERS/ASPIRIN
- DEFIBRILLATOR
- PACEMAKER
- RAPID HEARTBEAT WITH EPINEPHRINE
- PREGNANT OR PLANNING TO BECOME PREGNANT
- ARTIFICIAL HEART VALVE
- ARTIFICIAL JOINT PLACED WITHIN THE LAST TWO YEARS
- NEED TO PRE-MEDICATE PRIOR TO PROCEDURES
- HIV, HEPATITIS B OR C
- HEMOPHILA
- ORGAN TRANSPLANT RECIPIENT
- MALIGNANCY CANCER OR LEUKEMIA
- DIABETES MELLITUS TYPE 1 OR 2
- NONE OF THE ABOVE

Advanced Care Plan, Living Will, Health Care Proxy:

Please check the box that applies:

- ☐ **I have, with me today, an advance care plan (living will) and/or documentation of a surrogate decision maker. I will supply this information for inclusion in my medical record at the completion of this visit.**
- ☐ **I have an advance care plan (living will) and/or documentation of a surrogate decision maker but I did not bring it today. I will supply this information for inclusion in my medical record on my next visit.**
- ☐ **I do not wish or am not able to name a surrogate decision maker or provide an advance care plan.**

COMPLETE THIS SECTION *ONLY IF*: You are giving another person (spouse, family member, caregiver, etc.) authorization for our office to speak with them regarding your medical care.

Name of the person **(OTHER THAN YOURSELF)** you're authorizing with your medical care.

Print Name: _____ Relationship: _____

I hereby certify that the above information is true and correct to the best of my knowledge.

Patient or Representative Signature: _____ **Date:** _____