# *Hartford Dermatology Associates*

*History & Intake Form*

Name:_____Date of Birth:_____

Pharmacy Name/Address:_____

Primary Care Physician:_____Email:_____

Reason for today's visit:_____

_____

**Past Medical History: (Circle all that apply)**

| | | | |
|---|---|---|---|
| Anxiety | Cancer | Hepatitis | Radiation Treatment |
| Arthritis | Coronary Artery Disease | High Blood Pressure | Seizures |
| Asthma | Depression | HIV/AIDS | Stroke |
| Atrial Fibrillation | Diabetes | Hyperthyroid | Difficulty Healing |
| Bone Marrow Transplant | End Stage Kidney Disease | Hypothyroid | Organ Transplant |
| Other: | | | |
| | | | |

**Skin Disease History: (Circle all that apply)**

| | | | |
|---|---|---|---|
| Acne | Blistering Sunburns | Flaking/Itchy Scalp | Precancerous Moles |
| Actinic Keratosis | Dry Skin | Hay fever/Allergies | Psoriasis |
| Basal Cell Skin Cancer | Eczema | Melanoma | Squamous Cell Skin Cancer |
| Other: | | | |
| | | | |

Do you have a family history of melanoma? YES NO If yes, who?_____

If you are 65 years old or older, have you received the pneumonia vaccine? YES NO

Smoking history (circle one): Current smoker Former smoker Never smoker

**Medications (List or provide a list to copy):** _____

_____

_____

_____

_____

**Allergies (List all allergies):**_____

_____