THE DERMATOLOGY INSTITUTE OF BOSTON

Name: _____ Address: _____

Phone: _____ Email: _____ Date of birth: _____ □Male □Female

If we need to call you, may we leave detailed personal medical information (such as test results) on your voicemail? Yes No

Occupation: _____ Employer: _____

Emergency Contact Name: _____ Phone:_____ Relationship: _____

Primary Care Physician Name and Address: _____

Pharmacy Name and Address: _____

How did you hear about us? □Online search □Facebook □Twitter □Instagram □Newspaper □Word-of-mouth □Yelp.com □Work in this building

□Insurance website □Referred by another physician named: _____ □Other:_____

I would like to discuss the following (circle all that apply):

Acne scarring	Coolsculpting (fat removal)	Redness on face
Botox, Dysport, Xeomin	Laser for tattoo removal	Skincare
Brown spots	Laser hair removal	Veins on face
Chemical peels	Laser resurfacing	Other: _____
Filler injections	Microneedling	

Please list all previous cosmetic procedures/surgeries you have had:

_____

Have you ever been diagnosed with any medical conditions? If yes, please list and/or circle below.

_____

Acne	Cold Sores	Heart Murmur	Implanted Metal
Anxiety	Depression	Hepatitis B or C	Pacemaker
Artificial Joints	Diabetes	High Blood Pressure	Seizures
Bleeding Disorders	Eczema	HIV/AIDS	**Skin cancer (*list type*):**

What past illnesses or operations have you had?

_____

Has anyone in your family had a skin cancer? Who and what type of skin cancer? _____

What prescription medications, over the counter supplements, and vitamins do you currently take?

_____

Medication allergies: _____

Have you ever taken isotretinoin (aka Accutane)? Yes No When? _____

Do you use Retin-A, Renova, Adapalene, Differin, Tazarotene, Tazorac, Tri Luma or other retinol products? Yes No

Do you have a fever today? Yes No Do you have nausea today? Yes No

Do you have excessive bleeding problems? Yes No Do you develop keloid scars? Yes No

When were you last in the sun? _____ Are you tan now? Yes No Do you use tanning beds? Yes No

Smoking status: □Current smoker □ Former smoker □ Never smoker

For female patients: Are you pregnant or trying to get pregnant? Yes No Breastfeeding? Yes No

Patient signature: _____ Date:_____

Provider signature:_____ Date:_____