


# THE DERMATOLOGY INSTITUTE OF BOSTON

Legal Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_ Preferred Pronouns: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Email: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Gender (for Insurance Purposes): \_\_\_\_\_  
Self Identify : \_\_\_\_\_

 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: \_\_\_\_\_

In the event of a prescription, provide us with a 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, Jeuveau	Laser hair removal	Skincare
Brown spots	Laser resurfacing	Veins on face
Chemical peels	Microneedling	Other: _____
Filler injections	Platelet Rich Plasma (PRP)	

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	<b>Skin cancer (list type):</b>

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, Tretinoin, 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

Are you tan now? Yes No

Do you use tanning beds? Yes No

Have you ever fainted with medical procedures or blood draws? 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: \_\_\_\_\_