OPTUM®

1633 Medical Center Point
Colorado Springs, CO 80907

Dermatology – Patient intake information

Patient's name: _____ Date: _____/ _____/ _____

Reason for today's visit: _____

Check any of the following chronic conditions that you have been diagnosed with:

☐ Lung disorders	☐ Neurologic disorders	☐ Heart attack
☐ Cardiac disorders	☐ High blood pressure	☐ Lupus
☐ Thyroid disorders	☐ Diabetes	☐ Stroke/TIAs
☐ Kidney disorders	☐ High cholesterol	☐ Blood clots/DVTs
☐ Gastro disorders	☐ HIV/AIDS	

Current medications: Update the printed list provided, provide a list, or fill in all medications you are currently taking (including prescriptions, over-the-counter medications, vitamins and herbal supplements):

1. _____ 3. _____

2. _____ 4. _____

Allergies: Are you allergic to any medications? If so, please list: _____

Have you ever had a reaction to dental anesthesia (novocaine)? _____

Review of systems: Circle any of the following symptoms you have **experienced in the last three months:**

Fever	Chills	Feeling poorly	Feeling tired	Weight gain _____ lbs	Weight loss _____ lbs
Eye pain	Red eyes	Blurry vision	Eye discharge	Dry eyes	Itchy eyes
Difficulty swallowing	Hearing loss	Nose bleeds	Nasal discharge	Mouth sores	Hoarseness
Chest pains	Palpitations	Lower leg edema (swelling)			
Short of breath	Wheezing	Cough	Coughing up blood		
Abdominal pain	Constipation	Heartburn	Vomiting	Diarrhea	Blood in stool
Vaginal discharge	Penile discharge	Vaginal dryness	Blood in urine	Genital ulcers	Genital lesions
Morning joint stiffness lasting more than _____ mins	Joint pain	Joint swelling	Muscle weakness	Limb swelling	
Skin lesions	Skin wound	Itching	Mole changes	Skin rash	Dry skin
Color changes in cold	Sensitivity to sunlight	Skin feels tight	Hives	Hair loss	Nail changes
Headache	Confusion	Dizziness	Fainting	Convulsions	Difficulty walking
Deeper voice	Excessive hair growth				
Bruises easily	Bleeds easily	Swollen glands	Swollen glands (in neck)		

Past medical history

Have you ever had skin cancer? _____ When? _____

Have you ever been diagnosed with melanoma? _____ Where on the body? _____

History of any other specific skin diseases? _____

Do you develop keloids (scars) after surgery? _____

Surgical history

List surgical procedures you have had in the last six months. _____

Do you have a pacemaker? _____

Family history

Has anyone in your family had skin cancer? _____

Has anyone in your family had any other specific skin diseases? _____

Social history

Alcoholic drinks consumed per day? _____

IV drug use? _____ What type and how often? _____

Do you smoke? _____ What type and how much? _____

Are you pregnant? _____ Due date: _____/ _____/ _____

What is your occupation? _____

What are your hobbies? _____

Completed by

☐ Patient _____ Date: _____/ _____/ _____

☐ Medical assistant: Initials _____

☐ Registered nurse: Initials _____

Reviewed by: _____ Date: _____/ _____/ _____

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