DR. HILARY COSTELLO

HOLISTIC DERMATOLOGY ✵ NATUROPATHIC MEDICINE ✵ SKIN SURGERY

New Patient Dermatology Intake Form

Name_____ Date ____/____/____ Date of Birth ____/____/_____

Home Telephone (_____) _____ - _____ Work Telephone (_____) _____ - _____

Cell (_____) _____ - _____ Email _____

Address _____

How were you referred to us?_____

Please Check One: Married / Partnered: _____ Separated: _____ Divorced: _____ Widowed: _____ Single: _____

Emergency Contact: _____ Relationship: _____

Address: _____ Phone: _____

For minors, please not parent's name, birthday and SSN#: _____

Insurance Carrier: _____ Plan Name: _____

ID / Subscriber #: _____ Group #: _____

What are your dermatology health concerns? Please list in the order of importance to you.

1) _____

2) _____

3) _____

What are your primary expectations for the visit today?

1) _____

2) _____

Are you currently receiving health care? If yes, please list details of name/s of practitioner/s and purpose of medical care.

_____

_____

Are you taking medications or supplements? Please list with details of dosing.
For example, magnesium citrate 1000 mg per day twice a week for muscle pain, Ibuprofen 200 mg for occasional headaches

_____

_____

_____

Medical History: Do you have any of the following diseases, conditions, or history?
Please check all that apply.

___ Bleeding disorder, bruise easily
___ Herpes Simplex (cold sores)
___ Accutane Use
___ History of Skin Cancer
___ HIV/AIDS/Hepatitis B or C
___ Waxing / Plucking
___ Respiratory Condition
___ History of fainting
___ Keloid Scars
___ Aspirin Use
___ Previous Laser Treatment
___ Contact Lenses
___ History of poor wound healing
___ Anti-Aging Therapies
___ Heart Condition
___ Dental Work (fillings)
___ Facial Implants
___ Photo Allergic
___ Facial / Body Tattooing
___ Diabetes
___ Pigmentation Disorder
___ Hearing Aids
___ Metal Implants
___ Suntan
___ Pacemaker
___ Electrolysis
___ Epilepsy
___ Pregnant

Please describe significant medical history or concerns not listed above:

_____

_____

_____

Skin Type (when exposed to direct sunlight without protection for 1 hour - mark below)

_____ Always burn, never tans
_____ Usually burns, sometimes tans
_____ Sometimes burn, sometimes tans
_____ Always tans

___ White - Very Light ___ White - Light ___ White - Olive ___ Brown ___ Dark Brown ___ Black

Are you aware of having any allergies to the following? If so, please describe your reaction.

Drugs, including anesthesia: _____

Foods: _____

Chemicals/ Perfumes: _____

Herbal Medicine/ Essential Oils: _____

Current skin care routine and products used?

_____

_____

_____

I confirm that the above information is true and accurate.

_____ ____/_____/_____
Signature Date

_____
Printed name