Today's Date_____

Chatham Dermatology

Due to new requirements from the United States Department of Health and Human Services, we are requesting that all patients complete our Supplemental Patient Intake Form. We realize that some of the questions may be redundant. We appreciate your patience and apologize for any inconvenience.

Patient's Name (PRINT):_____

Date of Birth: _____/_____/_____ Sex: M ☐ F ☐ Patient Phone Number _____

We are in the process of implementing a Patient Portal to provide a communication option for our patients in compliance with Health and Human Service Requirements. Please provide a valid email address below:

(REQUIRED)_____@_____

Ethnicity: ☐ Non-Hispanic ☐ Hispanic

Language Preference: ☐ English ☐ Spanish Other: _____

Race: ☐ Caucasian or European American ☐ African or African American ☐ Asian or Asian American
☐ Native American or Native Alaskan ☐ Native Hawaiian or Other Pacific Islander ☐ Other

Family History of Skin Cancer? ☐ None ☐ Mother ☐ Father ☐ Sister ☐ Brother

Smoking Status:
☐ Never smoker
☐ Former smoker
☐ Current every day smoker
☐ Heavy tobacco smoker
☐ Unknown if ever smoked
☐ Smoker, current status unknown
☐ Current some day smoker
☐ Light tobacco smoker

Do you take any prescription or non-prescription medications?

☐ No ☐ Yes (If yes please list) _____

_____Dosage(s):_____

_____Dosage(s):_____

Allergies to Medications?

Reaction: _____

☐ No ☐ Yes (If yes please list) _____

Severity: ☐ Very Mild ☐ Mild ☐ Moderate ☐ Severe

Onset: ☐ Childhood ☐ Adult ☐ Unknown

Please check if you have a history of the following:

☐ Acne ☐ Herpes Zoster ☐ Psoriasis
☐ Depression ☐ Keloid Scar ☐ Rosacea
☐ Eczema ☐ Skin Cancer ☐ Sunburn
☐ Other_____

Signature: _____ Date: _____/_____/_____

(Parent or Guardian Signature if child is a minor)

Pharmacy Name_____, Pharmacy Phone Number_____