Date: _____

Parsons Dermatology and Cosmetics
INTAKE FORM

Name _____ Birth date (Month/Day/Year): _____

Address:_____Phone (Home):_____

Phone (Work):_____ Other Contact (email or cell phone) _____

Family Doctor:_____ Referring Doctor:_____

Health Card Number:_____ Pharmacy:_____

Reason for your visit today: _____

Please list **ALL** medical conditions

_____

_____

_____

_____

Please list **ALL** medications

_____

_____

_____

_____

Are you **pregnant** or **breastfeeding**? **Yes** _____ **No** _____

Are you on a **blood thinner**? (Aspirin, Plavix, Coumadin/Warfarin, other): **Yes** _____ **No** _____

Please list **any allergies** to medication: _____

Family History (Please circle any that apply): **Melanoma** **Eczema** **Psoriasis**

COSMETIC SERVICES

Did you know that Dr. Parsons provides many cosmetic services and can help with improving your overall skin health? Please let us know if you're interested in finding our more information about any of the following cosmetic concerns (Please circle):

Acne Scarring Ageing Skin Brown Spots Double Chin

Dull Skin Facial Volume Loss Fine lines and Wrinkles