



## Intake Forms

### 1. Please enter your information.

First Name: \_\_\_\_\_ Middle Initials: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Sex: \_\_\_\_\_ Gender: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
 Female  Male  Female  Male  Non-Binary  Single  Married  
 Transgender Female  Domestic Partner  Separated  
 Transgender Male  Divorced  Widowed

Street Address: \_\_\_\_\_ Apt./Unit #: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Preferred contact method: \_\_\_\_\_  
 Mobile Phone  Home Phone  Work Phone  
 Email

### 2. Race (Please check all that apply):

- White  African American  Asian  
 American Indian/Native Alaskan  Native Hawaiian/Pacific Islander  Other

If other, please specify:

\_\_\_\_\_

### 3. Emergency Contact:

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City, State & Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Alt. Phone: \_\_\_\_\_

### 4. Individuals with whom you allow us to share your health information:

	Name	Relationship
1		

**5. Family Doctor & Preferred Pharmacy:**

Family Doctor:	Phone:
_____	_____
Other Health Provider:	Phone:
_____	_____
Preferred Pharmacy:	Pharmacy Phone:
_____	_____
Pharmacy Address:	
_____	

**6. What Brings You In Today?**

- Acne/Rosacea
- Cyst/Abscesses
- Nail Issue
- Other
- Acne Accutane
- Hair Loss
- Rash/Bite/Other
- Bite
- Mole/Growth of Skin
- Refill

**7. Refill Visit Refills may be authorized up to 3 months in most cases. If lab work is required, convert to a full visit. If labs were completed, upload them later in form. We do not prescribe or refill controlled substances.**

- New Patient    New Returning Patient (not seen in past 3 years)    Follow Up

Current Diagnosis	Name of the last prescriber
_____	_____

Last visit for this condition with provider	Is your condition stable on medication requested?
_____	<input type="radio"/> Yes <input type="radio"/> No

Enter medication(s) requiring refills. Include name, vehicle (tab, cream, lotion, gel, foam), amount (g, #tab, mL), frequency of administration and instructions.

\_\_\_\_\_

Are you experiencing side effects of the medication? Describe if "yes".

\_\_\_\_\_

Females: Are you currently pregnant or could be pregnant?	Females: Are you breastfeeding?
<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No

Please add any other information that may benefit your medical evaluation.

\_\_\_\_\_

**8. Acne**

- New Patient    New Returning Patient (not seen in past 3 years)    Follow Up

Acne Lesions

- Clogged pores (whiteheads, blackheads)
- Red bumps (no cores or exudate)
- Pimples w/white core  Deep tender cysts
- Scars  Other

Areas Of Skin involved

- Face  Scalp  Back of Neck  Front of Neck
- Back  Chest  Arms  Legs
- Buttock (cheeks)  Buttock Creases
- Buttock Cleft (gluteal cleft)  Groin  Axillae
- Under Breasts  Abdominal Skin Fold

How long have you had acne for? Does it come and go?

What makes it better?

Prior products tried that failed. Describe side effects if any.

What products and treatments are you using now? Are there side effects?

Is there any other information about your acne that you would like too include here?

Are you able to become pregnant? (If you no longer have both ovaries and uterus or are post menopausal, answer No)

Yes  No

If YES, 1st day of your last menstrual period

- I am currently Pregnant
- I am Breastfeeding

If you were born with ovaries and uterus and answered No above, describe why you can not become pregnant

Would you like to have any acne medication refilled or have a medication request?

Yes  No

If YES, enter Medication Name, Potency (%), Dose (mg, ml), Frequency (daily, twice daily, as needed), Vehicle (tab, cap, cream, gel, lotion, other), Amount (mL, g, #caps)

Other lesion types

Other areas of skin involvement

Are there known acne triggers?

What makes it worse?

Products tried that worked

9. Mole/Skin Growth

- New Patient
- New Returning Patient (not seen in past 3 years)
- Follow Up

Describe the nature of your skin issue

Have you previously been given a diagnosis or recommended treatment?

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Lesion location? (ex. eyelids, face, arms, tops of hands, etc)

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When did you first notice this growth/mole?

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What prompted you to seek advice or treatment regarding this growth or mole?

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Has the growth or mole been changing in

Size  Color  Ulceration  Bleeding  Symmetry

Itching

Not at all  Mild  Moderate  Severe

Tingling

Not at all  Mild  Moderate  Severe

Pain

Not at all  Mild  Moderate  Severe

Redness

Not at all  Mild  Moderate  Severe

Drainage of fluid or pus

Not at all  Mild  Moderate  Severe

Do you have history of severe sunburns and prolonged sun exposure?

Yes  No

Do you have family history of Skin Cancer?

Yes  No

Is there anything else you would like your doctor to know about this condition?

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What treatments were attempted so far and did they work?

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## 10. Rash/Bite/Other

New Patient  New Returning Patient (not seen in past 3 years)  Follow Up

Describe the issue you're experiencing.

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What area(s) of the body is your skin problem located? (ex. eyelids, face, arms, tops of hands, etc)

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How long have you had this problem?

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Does it come and go?

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What may have triggered it?

Has it been formally diagnosed?

Was a skin biopsy done? What were results if, yes?  
 No  Yes

How severe is this problem?  
 Mild  Moderate  Severe

Have you tried anything to treat this problem? Did it work?

What medications are you using currently to treat the condition?

Is there Itching  
 No  Mild  Moderate  
 Severe

Burning  
 No  Mild  Moderate  
 Severe

Tingling  
 No  Mild  Moderate  
 Severe

Numbness  
 No  Mild  Moderate  
 Severe

Pain  
 No  Mild  Moderate  
 Severe

Blisters  
 No  Mild  Moderate  
 Severe

Flaking/Scaling of skin  
 Yes  No

Drainage of fluid or pus  
 Yes  No

Redness  
 Yes  No

Swelling  
 No  Mild  Moderate  
 Severe

Fevers  
 Yes  No

Swollen lymph nodes  
 Yes  No

Flu-like symptoms in the past 2 months  
 Yes  No

Chills  
 Yes  No

Sore Throat  
 Yes  No

Is there anything else you would like your doctor to know about this condition?

Do you have any specific questions you would like answered?

### 11. Hair Loss

Describe your hair loss

New Patient  New Returning Patient (not seen in past 3 years)  Follow Up

When did you first notice hair loss?  
 <6 months  6 months -1 year  
 >1 Year  Comes and goes  
 Not sure

Other Symptoms  
 No (my scalp feels fine)  
 Itching  Burning  Pimples  
 Blisters  Scales  Redness

How are you treating hair loss today?

Areas of scalp involved  
 Receding frontotemporal hair line  
 Front  Back  Crown  
 Right Side  Left Side  
 All Over  
 None, I am trying to prevent hair loss

Are you loosing hair of  
 Yes body  Yes face  
 Yes arms  Yes Legs  
 Yes genitalia  Yes axillae  
 No

What is your preferred treatment approach?  
 Just starting, prefer to start slowly and see what happens  
 I tried other treatments - would like to be more proactive  
 I would like to try the most potent available therapies

Preferred method of treatment  
 Topical (applied to the scalp)  
 Oral pill/cap (ingested by mouth)  
 I do not have a preference

Past Hair Loss Medications Medications Tried  
 Topical minoxidil  Oral Minoxidil  
 Topical Finasteride  
 Oral Finasteride - Propecia/Proscar  
 Topical Dutasteride  Oral Dutasteride  Other  
 None

Other treatment tried in the past  
\_\_\_\_\_

Did you experience side effects to any of the above treatments?  
\_\_\_\_\_

Is anyone in your household currently pregnant, trying to become pregnant, breastfeeding  
\_\_\_\_\_

When was your last check up with primary Care Doctor?  
 < 1 year  > 1 year  > 2 years  > 3 years  
 I do not recall

What is your Blood pressure reading?  
 < 100/65  Approximately 120/80  
 Approximately 140/90  Approximately 150/100  
 > 160/110

What is your current weight?  
\_\_\_\_\_

Have you been diagnosed with any of the following:  
 Heart Condition  Vascular Disease  Cancer  
 Sexual Dysfunction  Kidney disease  
 Liver Disease  Eye disease  Endocrine disease  
 Mental Health Conditions  Other Condition  
 None of the above

If yes to above, how are you treated? Is the condition stable?  
\_\_\_\_\_

Do you have a specific medication request?  
\_\_\_\_\_

What was your Sex assigned at birth?  
 Male  Female

If Female at birth, are you able to become pregnant? if not explain why?  
 Yes  No

If Female at birth, are you post menopausal?  
 Yes (I am postmenopausal naturally or after surgery (ovaries and uterus were removed surgically))  No

## 12. Lab Test Orders

New Patient  New Returning Patient (not seen in past 3 years)  Follow Up

Laboratory test you need ordered

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Specify if they are blood, urine, skin swab, other type

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Let us know if there is a preferred Laboratory to submit the ordered to (Include Fax and Phone Number)

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Laboratory Address:

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Telephone number:

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Fax Number:

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Email address if available:

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Where should the lab submit results to?

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**13. Upload photos related to todays visit.**

Description (optional)

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## Review of Systems Are you experiencing any of the following today?

Do you have any problems with the following? Please check the correct box:

**14. Constitutional**

- Lethargy
- Fevers/Chills
- Unexplained weight loss
- Unexplained weight gain
- Night Sweats

Explain (optional)

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**15. Neurological:**

- Confusion
- Dizzy/Lightheaded
- Headaches
- Memory problems

Explain (optional)

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**16. Eyes:**

- Blurry/Double Vision
- Burning
- Redness
- Loss of Vision

**Explain (optional)**

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**17. Ear/Nose/Throat:**

- Congestion
- Ear Pain
- Facial pain/numbness
- Hoarseness
- Nose bleeds
- Sinus pain
- Ringing in the Ears

**Explain (optional)**

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**18. Respiratory:**

- Blood in Sputum
- Persistent Coughing
- Shortness of Breath
- Sleep Apnea
- Snoring

**Explain (optional)**

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**19. Cardiovascular:**

- Angina/Chest Pain
- Ankle Swelling
- Exercise Intolerance
- Heart Palpitation
- Leg Pain with Walking
- Wake Short of Breath

**Explain (optional)**

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**20. Gastrointestinal:**

- Abdominal Pain
- Blood in Stool
- Black Stool
- Bloating
- Constipation
- Diarrhea
- Food Intolerance/Sensitivity
- Heartburn
- Nausea/Vomiting
- Stool Incontinence

**Explain (optional)**

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**21. Genitourinary:**

- Blood in urine
- Nighttime urination
- Heavy/Painful Menses
- Infertility
- Impotence
- Prostate Problems
- Urine Incontinence

**Explain (optional)**

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**22. Allergy/Immunology:**

- Frequent Infections
- Swollen Glands
- Past Anaphylaxis
- Seasonal Allergies

**Explain (optional)**

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**23. Hematology:**

- Bleed/Bruise Easily
- Blood Clots
- Past Blood Transfusion

**Explain (optional)**

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**24. Musculoskeletal:**

- Joint Pain
- Joint Swelling
- Muscle Pain

**Explain (optional)**

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**25. Skin/Breast:**

- Breast Lump
- Skin Rash

**Explain (optional)**

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**26. Psychiatric:**

- Anxiety
- Poor Sleep
- Depression
- Disordered Eating

**Explain (optional)**

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## Medical History

27. Do you have now (or have you ever had):

	Yes	No	Past
Anxiety	Yes	No	Past
Asthma/Emphysema	Yes	No	Past
Arthritis	Yes	No	Past
Blood Clots	Yes	No	Past
Bowel disease	Yes	No	Past
Chronic Pain	Yes	No	Past
Depression	Yes	No	Past
Diabetes Type I	Yes	No	Past
Diabetes Type II	Yes	No	Past
Eye Disease	Yes	No	Past
Heart Attack/Angina	Yes	No	Past
Heart Disease	Yes	No	Past
High Cholesterol	Yes	No	Past
High Blood Pressure	Yes	No	Past
Immune Disorder	Yes	No	Past
Kidney Disease	Yes	No	Past
Kidney Stones	Yes	No	Past
Liver Disease	Yes	No	Past
Migraines	Yes	No	Past
Neurologic Disorder	Yes	No	Past
Osteoporosis	Yes	No	Past
Recurrent Infections	Yes	No	Past
Seizures/Epilepsy	Yes	No	Past
Stroke/TIA	Yes	No	Past
Thyroid Problems	Yes	No	Past
Vascular Disease	Yes	No	Past

28. Do you have now (or have you ever had):

	Yes	No	Past	Location/Type
Cancer	Yes	No	Past	
Implanted Device	Yes	No	Past	
Radiation	Yes	No	Past	
Other		No	Past	

If yes, please explain

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29. Are there other medical conditions you want to add to your history?

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## Surgical History

30. Did you ever have a surgery?

Yes

No

31. Please list your previous surgeries:

	Operation	Month/Year
1		
2		
3		

32. list of Medications you take:

	Medication Name	Dosage	Frequency	Reason for taking
1				
2				
3				

33. Allergies?

Yes

No

**34. List our Allergies and include reaction:**

	Allergy	Reaction
1		
2		
3		

**35. FEMALES:**

Date of Last menstrual period:

Age at first period:

Are you on contraceptives?

Yes  No

If yes, please name:

Menopause?

Hysterectomy?

Ovaries removed?

Hormone replacement?

Yes  No

List:

**36. MALES:**

Vasectomy?

Yes  No

Impotence?

Yes  No

Erectile Dysfunction?

Yes  No

Weak urine stream?

Yes  No

## Social Health

**37. Do you:**

Smoke?

Yes  No  Past

If past, date quit:

Packs/Day:

Years:

Drink alcohol?

Yes  No  Past

If past, date quit:

Have you ever felt a need to cut down on your drinking?

Yes  No

Use Sunscreen

Daily  Occasionally  No

Are you pregnant?

Yes  No

Are you breastfeeding?

Yes  No

Are you able to become pregnant?

- Yes, I have ovaries and a uterus, and I am not post menopausal
- No, I do not have ovaries and a uterus, or I am post menopausal

If you had a surgical procedure to remove reproductive organs, describe bellow.

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**38. Drink alcohol?**

- Yes
- No
- Past

Medication name:

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**39. If yes, how many times per week:**

- 5 or more times per week
- 3-4 times per week
- 1-2 times per week
- Less than 1 time per week

**40. Sexually Active?**

- Yes
- No

**41. Do you wear sunscreen daily?**

- Yes
- No
- At times

## Family History

**42. Do you have a family (parent, sibling or child) history of:**

	Yes	No	If yes, who?
Alzheimer's disease	Yes	No	
Heart Disease	Yes	No	
Stroke	Yes	No	
High Blood Pressure	Yes	No	
Diabetes	Yes	No	
Cancer	Yes	No	
Mental Illness	Yes	No	

If with Cancer/Mental Illness, please specify type:

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## Health Maintenance

**43. Please indicate results (if known):**

Colonoscopy:  
 Polyps  Diverticulosis

Other:  
\_\_\_\_\_

Bone Density:  
\_\_\_\_\_

Chest X-ray:  
\_\_\_\_\_

Cholesterol:  
\_\_\_\_\_

EKG:  
\_\_\_\_\_

Thyroid/TSH:  
\_\_\_\_\_

**44. Check off any received Immunizations and enter date (if known):**

Flu Vaccine

Hepatitis

Pneumonia Vaccine

\_\_\_\_\_  
 Tetanus (Td)

\_\_\_\_\_  
 Other:

\_\_\_\_\_  
If other, please specify:  
\_\_\_\_\_

## Social History

**45. Do you see/talk to someone you feel close to more than once a week?**

Yes

No

**46. Have you travelled outside of the country in the last 2 years?**

Yes

No

If yes, where?  
\_\_\_\_\_

## Education/Employment

**47. Occupation:**  
\_\_\_\_\_

**48. Exposure to chemicals/hazardous materials?**

Yes

No

If yes, please explain:  
\_\_\_\_\_

49. To be completed and signed by the Responsible Party. This is a confidential medical platform protected with SSL and following HIPPA rules. I authorize treatment via the telemedicine platform. I understand that telemedicine is a useful tool, but it is not a substitute for in-person physical and laboratory evaluation. I will proceed to the Emergency room or in-person doctor's office if I am not feeling well or experiencing side effects of medications. I will seek immediate medical care by calling or texting the 988 Suicide and Crisis Lifeline if I feel like hurting myself or others and will proceed to the nearest ER, Urgent Care, or Doctor's office. I am solely responsible for my or my dependent's (patient you filled out forms for) medical care payments. I authorize the release of any medical information necessary to process my insurance claim and payment of benefits if insured.

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Enter Responsible Party Signature

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Signature

---

Date

50. Upload a copy of your Government issued ID

Type of ID

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51. At no additional charge to you we can fill out your insurance forms and you can submit them to the insurance company for payment. Do you have Medical Insurance?

Yes

No

52. Primary Insurance

Primary Insurance Company

Member ID / Policy #

Group Number

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Client Relationship to Insured

Self  Spouse  Child  Other

Insured Name

Insured Phone #

Insured Date of Birth

Insured Gender

Female  Male

Insured Street Address

Insured City

Insured State

Zip Code

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Do you have secondary insurance?

Yes  No

53. Secondary Insurance

Secondary Insurance Company

Member ID / Policy #

Group Number

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Client Relationship to Insured

Self  Spouse  Child  Other

Insured Name	Insured Phone #	Insured Date of Birth	Insured Gender <input type="radio"/> Female <input type="radio"/> Male
Insured Street Address	Insured City	Insured State	Zip Code

**54. Upload photos of insurance cards, Front and Back**

Authorization to treat via Telehealth platform. This is not an in-person visit. Please sign below.

_____	_____
Signature	Date

**55. I authorize the release of any medical information necessary to process my insurance claim and payment of benefits. I am solely responsible for my medical bill or the portion of it that insurance may not cover or pay for.**

\_\_\_\_\_