WARMUTH
INSTITUTE OF DERMATOLOGY
MEDICAL ▪ SURGICAL ▪ COSMETIC

Dermatology Medical History

Patient: _____ Date of Birth: ___/___/_____ Today's Date: __/___/___

Reason for today's visit: _____

Past Medical History: (please circle all that apply)

Anxiety	Cancer	GERD	Lung
Arthritis	Chronic Cold Sores	Hearing Loss	Lymphoma
Artificial Joints	Colon Cancer	Hepatitis	Pacemaker
Asthma	COPD	Hypertension	Prostate Cancer
Atrial Fibrillation	Coronary Artery Disease	HIV/AIDS	Radiation Treatment
BPH	Diabetes Seizures	Hypercholesterolemia	Stroke
Bone Marrow Transplantation	Depression	Hyperthyroidism	Valve Replacement
Breast Cancer	End Stage Renal Disease	Leukemia	None

Other: _____

Past Surgical History: (please circle all that apply)

Appendix Removed	Coronary Artery Bypass	Kidney Removed (Right, Left)	Ovaries Removed: Endometriosis TURP
Bladder Removed	Gallbladder Removed	Kidney Stone Removal	Ovaries Removed: Cyst Ovaries
Breast Biopsy (Right, Left, Bilateral)	Heart Transplant	Kidney Biopsy	PTCA
Breast Reduction	Hysterectomy: Uterine Cancer	Kidney Transplant	Removed: Ovarian Cancer
Breast Implants	Hysterectomy: Fibroids	Lumpectomy (Right, Left, Bilateral)	Removed Testicles Removed, (Right, Left, Bilateral)
Basal Cell Cancer Surgery	Joint Replacement within last 2 years	Mastectomy (Right, Left, Bilateral)	Skin Biopsy
Biological Valve Replacement	Joint Replacement, Knee (Right, Left, Bilateral)	Mechanical Valve Replacement	Spleen Removed
Colectomy: Colon Cancer Resection	Joint Replacement, Hip (Right, Left, Bilateral)	Melanoma Surgery	Squamous Cell Carcinoma Surgery

Other: _____

Skin Disease History: (please circle all that apply)

Acne	Hay Fever/Allergies
Actinic Keratosis	Melanoma
Asthma	Poison Ivy
Basal Cell Skin Cancer	Precancerous Moles
Blistering Sunburns	Psoriasis
Dry Skin	Squamous Cell Skin Cancer
Eczema	None
Flaking or Itchy Scalp	Other: _____

Do you wear sunscreen? Yes No If yes, what SPF? ____ Do you tan in a tanning salon? Yes No
Do you have a family history of Melanoma? Yes NO If yes, which family relative(s)? _____
Any other Family history? _____

Medications: (Please enter all current medications)

_____

Allergies: (Please enter all allergies)

_____

_____

Social History: (please circle all that apply)

Cigarette Smoking:

Never smoked
Quit: former smoker
Smokes less than daily
Smokes daily

Sexual History:

Not sexually active
Sexually active with one partner
Sexually active with more than one partner
Same sex partner

Illicit Drug Use:

Drug Use
IV Drug Use

Alcohol Use:

Never
None
Less than 1 drink a day
2-3 drinks a day
3 or more drinks a day

Safety:

I feel safe at home
I do not feel safe at home

Exercise:

Several times a day
Once a day
Few times a week
Few times a month
Never

Caffeine Use:

Several times a day
Once a day
Few times a week
Few times a month

First Degree Relative Medical History: (Parents, Siblings or Children)

Anxiety	COPD	Hepatitis	Lymphoma
Arthritis	Coronary Artery Disease	Hypertension	Prostate Cancer
Asthma	Depression	HIV/AIDS	Radiation Treatment
Atrial Fibrillation	Depression	Hypercholesterolemia	Seizures
BPH	Diabetes	Hyperthyroidism	Stroke
Bone Marrow Transplantation	End Stage Renal Disease	Hypothyroidism	Smoker
Breast Cancer	GERD	Leukemia	Valve Replacement
Colon Cancer	Hearing Loss	Lung Cancer	Chronic Cold Sores

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Cancelation Policy

When you make an appointment with one of our providers, we set aside an appointment time specifically for you. If you miss an appointment, it can't be filled by another patient in need of our services. Therefore, any missed or canceled appointments within 24 hours will result in a $50.00 charge to be billed directly to the patient. ____ (**please initial**)

Thank you in advanced for your cooperation in this matter, and we look forward to providing you with the utmost in medical care.

Patient or Responsible Party Signature_____ Date___/____/_____

Receipt of Notice of Privacy Practice:

My signature below indicates that I have received and/or reviewed a copy of my physicians Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices).

Patient or Responsible Party Signature_____ Date___/____/_____

Biopsy Results:

Please put the names of any person(s), that we will be able to discuss your medical information with.

I hereby give permission for the providers of Ingrid P. Warmuth, MD PA to discuss my biopsy results from all dates of service with the following people:

Name	***Birth Date***	***Telephone***

Signature _____

Date _____

Cosmetic Skin Care Form

Thank you for choosing Dr. Ingrid Warmuth Skin Care Center for your skin care needs. Our office provides high quality care and our philosophy is to actively listen to your needs and offer you the best care possible. In order to help us provide that care, please assist us by completing this form.

Name: _____ Email: _____

How did you hear about us…?

Through a patient? Please tell us who so we can thank them. _____
A referral from a family member or friend? Please let us know who. _____
A referral from your physician? Please tell us your doctor's first and last name. _____

Social Media Outlets

Website	www.warmuthinstitute.com	
Facebook	www.facebook.com/ingridwarmuthmd	
Twitter	www.twitter.com/dringridwarmuth	
Instagram	@warmuthinsitute	
Commercials	Comcast Cable and Pandora	

News Papers	Magazines	Phone Books	Placement Advertisements
The Daily Journal	Art of Living Well	Bridgeton/Millville Phone Book	Harrison House Diner
South Jersey Times	Clipper Magazine	Salem County Phone Book	Swedesboro Diner
The Elmer Times	Press Suburban Family Magazine	Superpages	Woodstown Diner
The New Town			
Cumberland County	Cumberland-Salem County Guide		

1. Describe your skin type: ☐ Normal ☐ Oily ☐ Combination ☐ Sensitive

2. What skin care products are you currently using? _____
_____

3. Do you experience any allergic reactions to any skin care products? ☐ Yes ☐ No
_____

4. Are you interested in learning about:

☐ Botox/Dysport/Xeomin ☐ Fillers ☐ Chemical Peels ☐ Laser/Light Treatment

☐ Microdermabrasion ☐ Any Resurfacing Treatment ☐ Anti-Aging Treatments

☐ Skin Care ☐ Facials ☐ Makeup ☐ Acne Treatments

5. Please check any concerns you might have regarding your face or body rejuvenation:

☐ Wrinkles ☐ Acne ☐Rosacea ☐Opened Pores ☐White/Black Heads

☐ Dark circles around eyes ☐ Skin Discoloration ☐ Sun Damage ☐ Broken Vessels

☐ Varicose Veins ☐ Excessive Hair Growth ☐ Hair Loss ☐ Tattoos ☐ Scarring

☐ Nail Changes ☐ Excessive Fat ☐ Stretch Marks ☐ Skin Atrophy/Thinning/Laxity

☐ Short Eye Lashes ☐ Thin Lips ☐ Other _____

6. Are you trying to become pregnant? ☐ Yes ☐ No