Dermatology Professionals History and Intake Form (R7) **Time:**________________

Account #________________

PBL NTM BRW KMB JAT

Patient Name: ____ Date of Birth__________________________

New Patient ______________

Height _________________________ Weight__________________________ Est. Patient _______________

Primary Care Physician ____

Preferred Pharmacy ____City__________________________________

Have you ever been diagnosed with cancer? Yes or no If yes, what type ________________________

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Artificial Joints
Asthma
Atrial Fibrillation
BPH
Bone Marrow Transplant
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
Renal Disease
GERD (Acid Reflux)
Hearing Loss
Hepatitis
Hepatitus C
High Blood Pessure
High Cholesterol
HIV/AIDS
Hypothyroidism
Hyperthyroidism
Leukemia
Lung Cancer
Lymphoma
Neuropathy
Prostate Cancer
Radiation Treatment
Rheumatoid Arthritis
Seizures
Stroke
Valve Replacement

Other: ______________________

____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Basal Cell Cancer Surgery
Biological Valve Replacement
Breast Biopsy (Right, Left, Both)
C-Section
Colectomy
Coronary Artery Bypass
Gallbladder Removed
Heart Transplant
Hysterectomy
Joint Replacement within last 2 years
Joint Replacement, Hip (Right, Left, Both)
Joint Replacement, Knee (Right, Left, Both)
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Lumpectomy (Right, Left, Both)
Mastectomy (Right, Left, Both)
Mechanical Valve Replacement
Melanoma Surgery
Ovaries Removed
Ovaries: Tubal Litigation
Prostate Biopsy
Prostate Removed: Prostate Cancer
Skin Biopsy
Tonsilectomy
TURP
Squamous Cell Carcinoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Both)
Wisdom Tooth Extraction

None
Other ____

Skin Disease History: (please circle all that apply)

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

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 relative(s)? ____
Any other family history: ____

Please List Current Medications & Vitamins

Medication ______________________ Dosage ____________ Frequency ____________
Medication ______________________ Dosage ____________ Frequency ____________
Medication ______________________ Dosage ____________ Frequency ____________
Medication ______________________ Dosage ____________ Frequency ____________
Medication ______________________ Dosage ____________ Frequency ____________

Medication Allergies: (include reaction)

Allergy: ____________ Reaction: ____________ Allergy: ____________ Reaction: ____________
Allergy: ____________ Reaction: ____________ Allergy: ____________ Reaction: ____________

Social History: (Please circle all that apply)

Alcohol Use: None <1 drink per day 1-2 drinks a day 3 or more drinks per day
Cigarette Smoking: Never former smoker Smokes less than daily smokes daily
Illicit Drug Use: Drug Use IV Drug Use
Do You Have A Pacemaker?: Yes or No
Do You Take An Anticoagulant Medication?: Yes or No If So, What Med? ________________

Alerts: Are you currently experiencing any of the following? **Please circle yes or no**

Allergy to adhesive **Yes no**
Allergy to lidocaine **Yes no**
Allergy to topical antibiotic ointments **Yes no**
Artificial heart valve **Yes no**
Artificial joints with past 2 years **Yes no**
Blood thinners **Yes no**
Defibrillator **Yes no**
History of MRSA **Yes no**
Pacemaker **Yes no**
Premedication prior to procedures **Yes no**
Rapid heartbeat with epinephrine **Yes no**
Pregnancy, planning a pregnancy or breast feeding **Yes no**