

Dermatology Professionals History and Intake Form (R7)

Time: _____

AEA TJG PBL NTM BRW KJN

Patient Name: _____ Date of Birth _____

Height _____ Weight _____ New Patient _____ 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	Diabetes (Type I or II)	Lung Cancer
Arthritis	Renal Disease	Seasonal Allergies
Osteoarthritis	GERD (Acid Reflux)	Lymphoma
Rheumatoid Arthritis	Hearing Loss	Neuropathy
Psoriatic Arthritis	Hepatitis	Prostate Cancer
Asthma	Hepatitis C	Radiation Treatment
Atrial Fibrillation	High Blood Pressure	Seizures
BPH (Enlarged Prostate)	High Cholesterol	Stroke
Bone Marrow Transplant	HIV/AIDS	Parkinson's Disease
Breast Cancer	Hypothyroidism	MS
Colon Cancer	Hyperthyroidism	Crohn's Disease
COPD	Leukemia	Immunosuppressed
Coronary Artery Disease	Ulcerative Colitis	Other _____
Depression	Cirrhosis (Liver Disease)	_____

Past Surgical History: (please circle all that apply)

Appendix	Lumpectomy (Right, Left, Both)
Bladder Removed	Mastectomy (Right, Left, Both)
Basal Cell Cancer Surgery	Mechanical Valve Replacement
Biological Valve Replacement	Melanoma Surgery
Breast Biopsy (Right, Left, Both)	Ovary Removed (Right, Left, Both)
C-Section	Ovaries: Tubal Ligation
Colectomy	Prostate Biopsy
Coronary Artery Bypass	Prostate Removed: Prostate Cancer
Gallbladder Removed	Skin Biopsy
Heart Transplant	Tonsillectomy
Hysterectomy	TURP (Prostate Resection)
Joint Replacement within last 2 years	Squamous Cell Carcinoma Surgery
Joint Replacement, Hip (Right, Left, Both)	Spleen Removed
Joint Replacement, Knee (Right, Left, Both)	Testicle Removed (Right, Left, Both)
Kidney Biopsy	Wisdom Tooth Extraction
Kidney Removed (Right, Left)	None
Kidney Stone Removal	Other _____
Kidney Transplant	

Have you had the Influenza Vaccine within the last year? Yes or No

Continue ->

Skin Disease History: (please circle all that apply)

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

Do you wear Sunscreen? Yes or No

If yes, what SPF? _____

Do you tan in a tanning salon? Yes or No

Do you have a family history of Melanoma? Yes or 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 take an Anticoagulant Medication (blood thinner)? Yes or No If so, what medication? _____

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

|                                                   |     |    |
|---------------------------------------------------|-----|----|
| Allergy to adhesives                              | 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 procedure                  | Yes | No |
| Rapid heartbeat with epinephrine                  | Yes | No |
| Pregnancy, planning a pregnancy or breast feeding | Yes | No |
| Immunosuppressed                                  | Yes | No |