Dermatology Professionals History and Intake Form (R7)

Time:_____

PBL NTM BRW KMB JAT

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 <u>circle</u> all that apply)

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

Past Surgical History: (please <u>circle</u> all that apply)

Appendix
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
Ovary Removed (Right, Left, Both)
Ovaries: Tubal Ligation
Prostate Biopsy
Prostate Removed: Prostate Cancer
Skin Biopsy
Tonsillectomy
TURP (Prostate Resection)
Squamous Cell Carcinoma Surgery
Spleen Removed
Testicle Removed (Right, Left, Both)
Wisdom Tooth Extraction
None
Other_____

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

Skin Disease History: (please <u>circle</u> 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?_____

Alerts: Are you currently experiencing any of the following? **Please <u>circle</u> 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**