Dermatology Professionals History and Intake Form (R7)

Time:_____

PBL NTM BRW AEA TJG

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 ☐No. If yes, what type? _____

Past Medical History: (please check 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
- ☐Cirrhosis (Liver Disease)
- ☐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
- ☐Other_____
- ☐Lung Cancer
- ☐Seasonal Allergies
- ☐Lymphoma
- ☐Neuropathy
- ☐Prostate Cancer
- ☐Radiation Treatment
- ☐Seizures
- ☐Stroke
- ☐Parkinson's Disease
- ☐MS
- ☐Crohn's Disease
- ☐Immunosuppressed
- ☐Depression

Past Surgical History: (please check 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_____

Other_____

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

Skin Disease History: (please check 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 ☐ 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 check 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 ☐ No If so, what medication?_____

Alerts: Are you currently experiencing any of the following? **Please check 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**