Dermatology Professionals History and Intake Form (R7)

Time:_____

PBL NTM BRW KJN AEA TJG KLJ

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**