Dermatology Professionals History and Intake Form (R7)

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?_____

Have you ever been diagnosed with? (please <u>circle</u> all that apply)

- ☐ None
- ☐ Anxiety disorder
- ☐ Asthma
- ☐ Arthritis
- ☐ Atrial Fibrillation
- ☐ Benign prostatic hyperplasia
- ☐ COVID-19
- ☐ Cerebrovascular accident
- ☐ Chronic obstructive lung disease
- ☐ Coronary arteriosclerosis
- ☐ Depressive disorder
- ☐ Diabetes mellitus
- ☐ Elevated blood pressure
- ☐ End-stage renal disease
- ☐ Epilepsy
- ☐ Gastroesophageal reflux disease
- ☐ H/O: hypertension
- ☐ Hearing loss
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Inflammatory disease of liver
- ☐ Leukemia
- ☐ Malignant lymphoma
- ☐ Malignant tumor of breast
- ☐ Malignant tumor of colon
- ☐ Malignant tumor of lung
- ☐ Malignant tumor of prostate
- ☐ Radiation therapy treatment
- ☐ Transplantation of bone marrow
- ☐ Other _____

Have you ever been diagnosed with? (please <u>circle</u> all that apply)

- ☐ None
- ☐ Appendectomy
- ☐ Biopsy of breast
- ☐ Biopsy of prostate
- ☐ Coronary artery bypass graft
- ☐ Entire transplanted kidney
- ☐ Excision of basal cell carcinoma
- ☐ Excision of melanoma
- ☐ Excision of squamous cell carcinoma
- ☐ Extraction of wisdom tooth
- ☐ H/O: colostomy
- ☐ H/O: tubal ligation
- ☐ History of appendectomy
- ☐ History of bilateral mastectomy
- ☐ History of cholecystectomy
- ☐ History of colectomy
- ☐ History of hernia repair
- ☐ History of percutaneous transluminal coronary angioplasty
- ☐ History of tissue graft heart valve rplmt
- ☐ History of total cystectomy
- ☐ History of transurethral prostatectomy
- ☐ History of trans prostatectomy -entire
- ☐ Hysterectomy
- ☐ Kidney biopsy
- ☐ Low anterior resection of rectum
- ☐ Lumpectomy (Right, Left, Both)
- ☐ Mastectomy (Right, Left, Both)
- ☐ Mechanical heart valve rplmt
- ☐ Oophorectomy
- ☐ Pancreatectomy
- ☐ Kidney stone removed
- ☐ Portosystemic shunt operation
- ☐ Prostatectomy
- ☐ Joint Rplmt, Hip (Right, Left, Both)
- ☐ Joint Rplmt, knee (Right, Left, Both)
- ☐ Splenectomy
- ☐ Surgical biopsy of skin
- ☐ Tonsillectomy
- ☐ Total nephrectomy
- ☐ Total orchidectomy
- ☐ Total rplmt of left hip joint
- ☐ Total rplmt of left knee joint
- ☐ Total rplmt of right hip joint
- ☐ Total rplmt of right knee joint
- ☐ Transplant of heart
- ☐ Transplant of liver

Other _____

Have you ever been diagnosed with? (please <u>check</u> all that apply)

- ☐ None
- ☐ Acne
- ☐ Actinic keratosis
- ☐ Asteatosis cutis
- ☐ Atopic dermatitis
- ☐ Basal cell carcinoma of skin
- ☐ Contact dermatitis
- ☐ Dry Skin
- ☐ Dysplastic nevus of skin
- ☐ Eczema
- ☐ H/O: Asthma
- ☐ H/O: Hay fever
- ☐ Malignant melanoma
- ☐ Pruritus of scalp
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Scalp itchy
- ☐ Seborrheic dermatitis
- ☐ Squamous cell carcinoma
- ☐ Sunburn of second degree
- ☐ Other: _____

Continue->

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: _____

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Medication Allergies: (include reaction)

Allergy: _____ Reaction: _____ Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____ Allergy: _____ Reaction: _____

For Patients 65 and older

Do you have an advanced care plan? ☐ Yes ☐ No

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 Anticoagulant Medication (blood thinner)? ☐ Yes ☐ No

If yes, what medication? _____

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

Email Address: _____