

Dermatology Professionals History and Intake Form

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)

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

Past Surgical History: (please check all that apply)

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

Email Address: _____

For Patients 65 and Older

- | | | | |
|--|-----|---|----|
| Have you received a pneumonia vaccination? | yes | o | no |
| Do you have an advanced care plan? | yes | o | no |
| Do you have a living will? | yes | o | no |

Continue->

Skin Disease History: (please check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Poison Ivy |
| <input type="checkbox"/> Actinic Keratosis | <input type="checkbox"/> Eczema | <input type="checkbox"/> Precancerous Moles |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Flaking or Itchy Scalp | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Basal Cell Skin Cancer | <input type="checkbox"/> Melanoma | <input type="checkbox"/> Rosacea |
| <input type="checkbox"/> Blistering Sunburns | <input type="checkbox"/> Squamous Cell Skin Cancer | <input type="checkbox"/> None |
- 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: _____

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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 yes, what medication? _____

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

- | | | |
|---|------------------------------|-----------------------------|
| Allergy to adhesives | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Allergy to lidocaine | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Allergy to topical antibiotic ointments | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Artificial heart valve | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Artificial joints with past 2 years | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blood thinners | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Defibrillator | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| History of MRSA | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Pacemaker | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Premedication prior to procedure | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Rapid heartbeat with epinephrine | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Pregnancy, planning a pregnancy or breast feeding | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Immunosuppressed | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
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