

History and Intake Form

Today's Date: _____

Patient Name: _____ D.O.B _____ Age: _____

Mailing Address: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Primary on insurance: _____ Insured's D.O.B: _____

Referred by: _____
 M.D Self/Friend

Height: _____ (inches) Weight: _____ (lbs.)

Main skin problem you want evaluated? _____

1. Body area: _____ Duration: _____

2. Previous treatment (all medicine used): None

3. Changes: None Color Size Elevation Hardness

4. Modifying factors: None History of Skin Exposure Other Immune Diseases Other Illness: _____

5. Symptoms: None Bleed Itch Pain Infection

6. Severity: None Occasional Constant

Complete list of all other skin areas, growths, skin symptoms, or questions you have:

Person who I agree to release medical information to: _____

In Case of Emergency: _____ Phone: _____ Cell: _____

May we leave personal medical information on your answering machine or cellphone? Yes No

Past Medical History: (Please check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression | <input type="checkbox"/> Lung Cancer |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> Atrial fibrillation (Irregular Heartbeat) | <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Bone Marrow Transplantation | <input type="checkbox"/> GERD | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Benign Prostatic Hyperplasia (BPH) | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> High Blood pressure | |
| <input type="checkbox"/> COPD | <input type="checkbox"/> HIV/AIDS | |
| | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> NONE |
| | <input type="checkbox"/> Hypothyroidism | |
| | <input type="checkbox"/> Hyperthyroidism | |

Other _____

Past Surgical History: (Please check all that apply)

- Appendix Removed
- Bladder Removed
- Breast
 - Breast Biopsy
 - Mastectomy (Right, Left, Bilateral)
 - Lumpectomy (Right, Left, Bilateral)
 - Breast Implants
- Colon
 - Colectomy: Colon Cancer Resection
 - Colectomy: Diverticulitis
 - Colectomy: Inflammatory Bowel disease (IBD)
- Gallbladder Removed
- Heart
 - Coronary Artery Bypass
 - Mechanical Valve Replacement
 - Biological Valve Replacement
 - Heart Transplant
 - PTCA
- Joint Replacement
 - Joint replacement within last 2 years
 - Hip (Right, Left Bilateral)
 - Knee (Right, Left, Bilateral)
- Kidney
 - Kidney Biopsy
 - Kidney Removed (Right, Left)
 - Kidney Stone Removal
 - Kidney Transplant
 - Tubal ligation
- Kidney- Nephrectomy
- Liver
 - Hepatectomy
 - Liver Transplant
 - Shunt
- Ovaries
 - Ovaries Removed: Endometriosis
 - Ovaries Removed: Ovarian Cancer
 - Ovaries Removed: Cyst
- Pancreatectomy
- Prostate
 - Prostate Biopsy
 - Prostate Removed: Prostate Cancer
- Rectum Low Anterior Resection
- Skin
 - Basal Cell Carcinoma
 - Melanoma
 - Skin Biopsy
 - Squamous Cell Carcinoma
- Spleen Removed
- Testicles Removed (Right, Left, Bilateral)
- Uterus
 - Hysterectomy: Fibroids
 - Hysterectomy: Uterine Cancer
 - Cervical Cancer
- NONE

Other _____

Skin Disease History: (please circle all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Poison Ivy |
| <input type="checkbox"/> Actinic Keratoses | <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"/> Hay Fever/Allergies | <input type="checkbox"/> Squamous Cell Skin Cancer |
| <input type="checkbox"/> Blistering Sunburns | <input type="checkbox"/> Melanoma | <input type="checkbox"/> NONE |

Other _____

Do you wear Sunscreen? Yes, SPF _____
 No

Do you tan in a tanning salon? Yes
 No

Do you have a family history of skin cancer? Yes
 Melanoma- If yes, Which relative? _____
 Other: Basal Cell
 Squamous Cell
Which Relative? _____
 No

Medications: MANDATORY SECTION (Please enter all current medications including: Strength, Dose, Form, Frequency, Route and Unit)

Medication Name	Strength (i.e. mg, gram)	Dose (i.e. 5,10, 500)	Frequency (i.e. daily, at night)	Form (i.e. tablet, capsule)	Route (i.e. oral, topical)

If you have a med-list, please give a copy of the list to the medical assistant so that we can add medications to the computer

Allergies: (Please enter all allergies, include reaction)

_____ Reaction _____
 _____ Reaction _____
 _____ Reaction _____

Social History:

Smoking Status:

- Current every day smoker _____ → When did you start smoking? _____
- Current some day smoker (tobacco) _____ → Number of packs a day? _____
- Current some day smoker (cigarettes) _____ → Total years smoking? _____
- Former smoker
- Never Smoker
- Cigar Smoker

Alcohol Use (EtOH): None

- NONE
- Less than 1 drink per day
- 1-2 drinks per day
- 3 or more drinks per day

How many times in the past year have you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women or any adult older than 65?

- 0
- 1
- 2
- Greater than 2

Family History (Only **IMMEDIATE** relatives: Please list ANY OTHER Family History conditions (i.e. Cardiologic, Diabetes, any other type of Cancer, etc.))

IMPORTANT ALERTS: (Please check off any of the below alerts for our practice to be aware of)

- Allergy to Adhesive
- Allergy to lidocaine
- Allergy to topical antibiotics
- Artificial heart valve
- Artificial joint replacement
- Blood thinners
- Defibrillator
- MRSA
- Pacemaker
- Require antibiotics prior to a surgical procedure
- Rapid heartbeat with epinephrine

Are you pregnant or currently trying to get pregnant? Yes No

Do you have an Advanced Care Plan (Advanced Directive)? Yes Name of Surrogate:_____

No

Preferred Language: _____

Race:_____ Ethnic Group:_____

Only if you DO NOT wish to use our In-house dispensary, please note your pharmacy name down below:

Preferred pharmacy Name: _____

Phone#: _____ City or Zip code: _____

Review of Systems: Are you currently experiencing any of the following? If yes, please place a check mark in the boxes below. If none, please mark the "NONE" box.

Symptom:

<input type="checkbox"/> Problems with bleeding	<input type="checkbox"/> Blurry vision
<input type="checkbox"/> Problems with healing	<input type="checkbox"/> Abdominal pain
<input type="checkbox"/> Problems with scarring (hypertrophic or keloid)	<input type="checkbox"/> Bloody stool or urine
<input type="checkbox"/> Rash	<input type="checkbox"/> Joint aches
<input type="checkbox"/> Immunosuppression	<input type="checkbox"/> Muscle Weakness
<input type="checkbox"/> Hay fever	<input type="checkbox"/> Headaches
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Seizures
<input type="checkbox"/> Fever/ chills/ weight loss	<input type="checkbox"/> Cough
<input type="checkbox"/> Night sweats	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Neck stiffness	<input type="checkbox"/> Wheezing
<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Sore throat	<input type="checkbox"/> Depression
<input type="checkbox"/> NONE, I have none of these symptoms	

Other current symptoms that are not listed above:

Patient Signature: _____ Date: _____