History and Intake Form

Patient Name: ______________________________ D.O.B ____________ Age: ________

Referred by: ______________________________ Today's Date: ______________

❑ M.D ❑ Self/Friend

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: ______________________________

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

Past Medical History: (Please check all that apply)

❑ Anxiety
❑ Arthritis
❑ Asthma
❑ Atrial fibrillation
❑ Bone Marrow Transplantation
❑ Breast Cancer
❑ Colon Cancer
❑ COPD
❑ Coronary Artery Disease
❑ Depression
❑ Diabetes
❑ End Stage Renal Disease
❑ GERD
❑ Hearing Loss
❑ Hepatitis
❑ High Blood pressure
❑ HIV/AIDS
❑ High Cholesterol
❑ Thyroid Problems
❑ Leukemia
❑ Lung Cancer
❑ Lymphoma
❑ Prostate Cancer
❑ Radiation Treatment
❑ Seizures
❑ Stroke
❑ NONE

Other ______________________________

Past Surgical History: (Please check all that apply)

❑ Bladder Removed
❑ Breast
  ❑Mastectomy (Right, Left, Bilateral)
  ❑Lumpectomy (Right, Left, Bilateral)
  ❑Breast Implants
❑ Colon
  ❑Colectomy: Colon Cancer Resection
  ❑Colectomy: Diverticulitis
  ❑Colectomy: IBD
❑ Heart
  ❑Coronary Artery Bypass
  ❑Mechanical Valve Replacement
  ❑Biological Valve Replacement
  ❑Heart Transplant
  ❑PTCA
❑ Gallbladder Removed
❑ Joint Replacement
  ❑Knee (Right, Left, Bilateral)
  ❑Hip (Right, Left Bilateral)
  ❑Joint replacement within last 2 years
❑ Kidney
  ❑Kidney Removed (Right, Left)
  ❑Kidney Stone Removal
  ❑Kidney Transplant
❑ Liver
  ❑Hepatecomy
  ❑Liver Transplant
  ❑Shunt

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- ❑ Ovaries
  - ❑Ovaries Removed: Endometriosis
  - ❑Ovaries Removed: Cyst
  - ❑Ovaries Removed: Ovarian Cancer
  - ❑Tubal ligation
- ❑ Pancreatectomy
- ❑ Prostate
  - ❑Prostate Removed: Prostate Cancer
- ❑ Spleen Removed
- ❑ Testicles Removed (Right, Left, Bilateral)
- ❑ Skin
  - ❑ Basal Cell Carcinoma
  - ❑ Melanoma
  - ❑ Skin Biopsy
  - ❑ Squamous Cell Carcinoma
- ❑ Uterus
  - ❑ Hysterectomy: Fibroids
  - ❑ Hysterectomy: Uterine Cancer
  - ❑ Cervical Cancer
- ❑ NONE

Other ____

Skin Disease History: (please circle all that apply)

- ❑ Acne
- ❑ Actinic Keratoses
- ❑ Asthma
- ❑ Basal Cell Skin Cancer
- ❑ Blistering Sunburns
- ❑ Dry Skin
- ❑ Eczema
- ❑ Flaking or Itchy Scalp
- ❑ Hay Fever/Allergies
- ❑ Melanoma
- ❑ Poison Ivy
- ❑ Precancerous Moles
- ❑ Psoriasis
- ❑ Squamous Cell Skin Cancer
- ❑ 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
- ❑ Other - ❑ Basal Cell ❑ Squamous Cell

Which Relative? ____________________

❑ No

Medications: (Please enter all current medications)

____

____

____

Allergies: (Please enter all allergies)

____

____

____

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Social History: (Please circle all that apply)

Cigarette Smoking: ❑ Yes
❑ No

If yes, please answer the following:
- ❑ Currently Smokes
  - ❑Current every day smoker
  - ❑Current some day smoker (tobacco)
  - ❑Current some day smoker (cigarette)
- ❑ Has smoked in the past
- ❑ Never smoked
- ❑ Former Smoker

When did you start smoking?____________________
When did you quit smoking?____________________
Number of packs a day?____________________
Total years smoking?____________________

Alcohol Use (EtOH):
- ❑ None
- ❑ Less than 1 drink per day
- ❑ 1-2 drinks per day
- ❑ 3 or more drinks per day

Family History (Only first degree relatives) i.e. Hodgkin's disease, Lymphoma, Alcoholism:

____

ALERTS: (please circle all that apply)

- ❑ 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 or ❑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:____________________

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Review of Systems: Are you currently experiencing any of the following?
(Please place a check mark in the yes or no boxes provided)

Symptom	Yes	No
Problems with bleeding		
Problems with healing		
Problems with scarring (hypertrophic or keloid)		
Rash		
Immunosuppression		
Hay fever		
Chest pain		
Fever/ chills/ weight loss		
Night sweats		
Neck stiffness		
Thyroid Problems		
Sore throat		
Blurry vison		
Abdominal pain		
Bloody stool or urine		
Joint aches		
Muscle Weakness		
Headaches		
Seizures		
Cough		
Shortness of Breath		
Wheezing		
Anxiety		
Depression		

Other Symptoms:

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Patient Signature:___________________________ Date:______________

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