Central Dermatology Center

History and Intake Form – Established Patient

Patient Name: _____ Date of Birth: _____ Date: _____

(FOR PATIENTS 18 YEARS AND YOUNGER) Height: _____ Weight: _____

Primary Care Physician: (name, location) _____

Preferred Pharmacy: (name, city) _____

Email Policy Update: As of October 2020, the email address we have on file will be used for clinical communication (appointment & care reminders, medical information, test results), practice communication (announcements, newsletters, specials, events). We will never share or sell your email address. At any point, you may unsubscribe or opt-out of one or both types of communication. If you need to update your email address, please see one of our front desk associates.

REASON FOR VISIT:_____

Past Medical History: (circle all that apply)

Anxiety	Depression	Hepatitis	Breast Cancer
Arthritis	Diabetes	High Cholesterol	Colon Cancer
Asthma	End-stage Renal Disease	Hyperthyroidism	Prostate Cancer
Atrial Fibrillation	Epilepsy	Hypothyroidism	Pacemaker
Stroke	GERD	Immunosuppression	Radiation Therapy
COPD	High Blood Pressure	Liver Disease	Bone Marrow Transplant
Coronary Artery Disease	Hearing Loss	Leukemia	Seizures
Chemotherapy treatment	HIV/AIDS	Lymphoma	Valve Replacement
Other:		Lung Cancer	**NONE**

Past Surgical History: (circle all that apply)

Breast Implants	Tubal Ligation	Ovaries removed (cyst, ovarian cancer)	Hip Replacement (R, L, bilateral)
Breast Reduction	Heart Valve replacement	Pancreas removed	Knee replacement (R, L, bilateral)
Coronary Artery Bypass	Hysterectomy	Prostate removed (cancer)	Heart Transplant
Kidney Transplant	Lumpectomy (R, L, bilateral)	Spleen removed	Liver Transplant
Colostomy	Mastectomy (R, L, bilateral)	Kidney removed	

Other: **NONE**

Skin Disease History: (circle all that apply)

Acne	Dysplastic (atypical) mole	Hay fever/Allergies	Squamous Cell Skin Cancer
Actinic Keratosis (pre-cancers)	Eczema	Malignant Melanoma	Rosacea
Basal Cell Skin Cancer	Asthma	Psoriasis	

Other: **NONE**

Do you have **family** history of Malignant Melanoma? Yes / No If **yes**, which relative? _____

Do you have a **family** history of a non-melanoma skin cancer? Yes / No

Medications: Please list your current prescription and over the counter medications. *You may skip this section if providing a printed list to our rooming staff.*

_____ _____ _____

_____ _____ _____

_____ _____ _____

Drug Allergies: _____

Cigarette Smoking Never Smoker Former Smoker Current Every day Smoker Current smoker (less than daily)

Alcohol Use None Less than 1 drink a day 1-2 drinks a day 3 or more drinks a day

FOR PATIENTS 65 AND OLDER (circle yes or no):

Have you received a Pneumonia Vaccination? Yes / No

Do you have a health care proxy in the event you are unable to make your own medical decisions? Yes / N

Review of Systems:

Are you currently experiencing any of the following?

(please check yes or no for the following).

Symptom	Yes	No
Problems with bleeding		
Problems with healing		
Problems with scarring (hypertrophic or keloid)		
Immunosuppression		
Chest pain		
Shortness of breath		
Rash		
Changing mole		
Dry skin/lips		
Nosebleeds		
Unintentional weight loss		
Change in appetite		
Headaches		
Ringing in the ears		
Blurry vision		
Abdominal pain		
Bloody stool		
Joint aches		
Anxiety		
Depression		
Thoughts of hurting yourself or others		
Fever/chills		
Night sweats		
Sore throat		
Cough		
Muscle weakness		
Nausea or vomiting		
Irregular periods		
Seizures		
Dizziness		
Heat or cold intolerance		
Loss of taste/smell		
Body/muscle aches		
Bipolar Disorder		
Hidradenitis Suppurativa		

Other Symptoms:

_____

_____

Alerts:

Are any of the following true for current health?

(please check yes or no for the following)

Alert	Yes	No
Pregnancy or planning a pregnancy		
Defibrillator		
Pacemaker		
Blood thinners		
Artificial heart valve		
Premedication prior to procedures		
Artificial joints in past two years		
Taken isotretinoin in the last year		
Immunosuppression		
HIV		
Hepatitis B or C		
History of Cancer		
History of Melanoma		
Allergy to lidocaine		
Allergy to adhesive		
Allergy to topical antibiotic ointments		
Rapid heartbeat with epinephrine		
Yeast infections with antibiotics		
Gastrointestinal upset with antibiotics		
Breastfeeding		