History and Intake Form (Established Patient)

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

Primary Care Physician (name and location): _____

Reason for today's visit: _____ **Occupation** _____

How did you hear about us? Physician (Please specify)**:** _____

Recall letter Friend/Family CDC Website Other: (please specify) _____

Medical History: (circle all that apply)

Anxiety	COPD	Hepatitis (A, B, C)	Lymphoma
Arthritis	Coronary Artery	Hypertension	Pacemaker
Artificial joints	Disease	HIV/AIDS	Prostate Cancer
Asthma	Depression	Hypercholesterolemia	Radiation Therapy
Atrial Fibrillation	Diabetes	Hyperthyroidism	Seizures
BPH	End Stage Renal	Hypothyroidism	Stroke
Bone Marrow Transplant	Disease	Immunosuppressed	Valve Replacement
Breast Cancer	GERD	Leukemia	
Colon Cancer	Hearing Loss	Lung Cancer	**None**

Other_____

Surgical History: (circle all that apply)

Mastectomy (R, L, bilateral)	Heart Transplant	Ovaries removed (cyst, ovarian cancer)
Lumpectomy (R, L, bilateral)	Knee replacement (R, L, bilateral)	Prostate removed: prostate cancer
Breast reduction		Spleen removed
Breast implant	Hip replacement (R, L, bilateral)	Testicles removed (R,L, bilateral)
Colectomy	Joint replacement in past 2 years	Hysterectomy (fibroids, uterine cancer)
Coronary Artery Bypass	Kidney removed (R, L)	
Heart Valve Replacement	Kidney Transplant	**None**

Other_____

Skin Disease History: (circle all that apply)

Acne	Eczema	Psoriasis
Actinic Keratosis (pre-cancerous growths)	Flaking or Itchy Scalp	Rosacea
	Hay Fever/Allergies	Squamous Cell Skin Cancer
Basal Cell Skin Cancer	Melanoma	
Blistering Sunburns	Poison Ivy	**None**
Dry Skin	Precancerous Moles	

Other_____

Do you have a **family** (blood relative) history of melanoma**?** Yes/ No If yes which relative (s) _____

Do you have a **family** (blood relative) history of any other skin cancer(s)? Yes/ No If yes which relative(s) _____

Medications: (please list all current medications, including those used as needed, herbals and supplements)

_____

_____

Preferred Pharmacy: (Name, Street, City) _____

Drug or Contact Allergies: (please include your reaction) _____

Cigarette Smoking: Never Smoked Quit: Former smoker Smokes: Less than daily Smokes: Daily

Alcohol: None Less than 1 drink per day 1-2 drinks per day 3 or more drinks per

CONTINUE OVER THE PAGE.

Review of Systems: Are you **currently** experiencing any of the following? (please check yes or no)

Symptom	Yes	No
Problems with bleeding		
Problems with healing		
Problems with scarring (hypertrophic or keloid)		
Immunosuppression		
Rash		
Changing mole/ non-healing spot		

Other Symptoms: _____

Alerts: Are any of the following true for **current health**? (please check yes or no)

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

Any significant changes in medical history? _____

_____

Any changes in medications? _____

The web is becoming a key way patients learn about our practice. Do you participate in any of the following?

Yelp **Google** **Yahoo** **Angie's List** **Other Social Media (Please specify)** _____