CERTIFIED BY ABD
Glenn H. Brown, MD
American Board of Dermatology

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NAME: _____ DATE OF BIRTH: _____

History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety	Depression	Liver Disease
Arthritis (Rheumatoid/Psoriatic/Osteoarthritis)	Diabetes	Lung Cancer
Asthma	Dialysis	Lupus
Atrial fibrillation	End Stage Renal Disease	Lymphoma/Year
Auto Immune Disease	GERD (Acid Reflux)	Multiple Sclerosis
BPH (Benign Prostatic Hyperplasia)	Hearing Loss	Pacemaker
Bone Marrow Transplantation (For)	Hepatitis (A/B/C)	Prostate Cancer
Breast Cancer/Year	Hypertension	Radiation Treatment (Yr/When/Where)
Chemotherapy/Year	HIV/ AIDS	Seizures
Colon Cancer/Year	Hypercholesterolemia	Stroke
COPD (Emphysema)	Hyperthyroidism/Hypothyroidism	None
Coronary Artery Disease	Leukemia/Year	Other_____

Past Surgical History: (please circle all that apply & write the YEAR)

Appendix Removed	Mechanical Valve Replacement	Ovaries Removed: Endometriosis
Bladder Removed	Biological Valve Replacement	Ovaries Removed: Cyst
Mastectomy (Right, Left, Bilateral)	Heart Transplant	Ovaries Removed: Ovarian Cancer
Lumpectomy (Right, Left, Bilateral)	Joint Replacement, Knee (Right, Left, Bilateral)	Prostate Removed: Prostate Cancer
Breast Biopsy (Right, Left, Bilateral)		Prostate Biopsy
Breast Reduction	Joint Replacement, Hip (Right, Left, Bilateral)	TURP
Breast Implants		Skin Biopsy
Colectomy: Colon Cancer Resection	Kidney Biopsy	Basal Cell Carcinoma Surgery
Colectomy: Diverticulitis	Kidney Removed (Right, Left)	Squamous Cell Carcinoma Surgery
Colectomy: IBD	Kidney Stone Removal	Melanoma Surgery
Colon: Colostomy	Kidney Transplant	Spleen Removed
Gallbladder Removed	Liver: Hepatectomy	Testicles Removed (Right, Left, Bilateral)
Coronary Artery Bypass	Liver: Transplant	Hysterectomy: Fibroids
PTCA	Liver: Shunt	Hysterectomy: Uterine Cancer
Other_____		None

Skin Disease History: (please circle all that apply, if cancer write the YEAR)

Acne	Dry Skin	Poison Ivy
Actinic Keratoses/Precancers	Eczema	Precancerous Moles/Dysplastic Nevus
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/ Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	None
Other_____		

Do you wear Sunscreen?	Yes	No	**If yes, what SPF?** _____
Do you tan in a tanning salon?	Yes	No	**If yes, how many years?** _____
Do you have a family history of Melanoma?	Yes	No	**If yes, which relative(s)?** _____

Medications: (Please enter all current medications) _____

_____

_____

Allergies: (Please enter all allergies) _____

Allergies to meds? Which ones: _____

Social History: (Please circle one)

Place of Residence: _____

Do you live alone: _____

Occupation: _____

Cigarette Smoking:
Never smoked
Quit: former smoker
Smokes less than daily
Smokes daily

Alcohol Use:
NO
less than 1 drink per day
1-2 drinks per day
3 or more drinks per day

What is your caffeine use?
Once daily
A few times a week
A few times a month
Never

Men: How many times in the past year have you had 5 or more drinks in a day _____
Women: How many times in the past year have you had 4 or more drinks in a day_____

Race:
White
Black/ African American
Asian
American Indian or Native Alaskan
Native Hawaiian/ Pacific Islander

Ethnicity:
Hispanic/ Latino
Non-Hispanic/ Latino
Other:_____

Language:
English
Spanish
Other: _____

How often do you exercise?
Once a day
A few times a week
A few times a month
Never

How often do you drive:
__Drives in the daytime
__Drives at night

Pharmacy:

Name: _____

Main Intersection: _____

Address: _____Zip:_____

Phone: _____