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DERMATOLOGY
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NAME: _____ **DATE OF BIRTH: _____**

History and Intake Form

Past Medical History: (please circle all that apply, if none circle NONE) -

Anxiety Disorder	Arthritis	Asthma
Atrial Fibrillation	Autoimmune Disease	Benign Prostatic Hyperplasia (BPH)
Cardiac Pacemaker	Cerebrovascular Accident (Stroke)	Chemotherapy/Year
Chronic Obstructive Lung Disease (COPD)	Coronary Arteriosclerosis	Depressive Disorder
Diabetes Mellitus	Dialysis Care	End-Stage Renal Disease
Hypertension	Hearing Loss	History of Breast Implants
Human Immunodeficiency Virus Infection (HIV)	Hypercholesterolemia	Hyperthyroidism
Hypothyroidism	Inflam. Disease of Liver (Hepatitis)	Leukemia/Year
Lupus Erythematosus	Malignant Lymphoma/Year	Malignant Tumor of Lung/Year
Malignant Tumor of Ovary/Year	Malignant Tumor of Colon/Year	Malignant Tumor of Prostate
Multiple Sclerosis	Radiation Therapy Treatment/Year	Seizure
Transplantation of Bone Marrow	NONE	Other: _____

Past Surgical History: (please circle all that apply & write the YEAR, if none circle NONE) -

Appendectomy	Replacement of Knee Joints (R/L/B)	Biopsy of Breast
Biopsy of Prostate	Colostomy	Complete Cystectomy
Coronary Artery Bypass	Entire Transplanted Kidney	Heart Valve Replacement/Specify
History of Colectomy (IBD)	History of Mastectomy (R/L/B)	Hysterectomy
Kidney Excision (Left/Right)	Lumpectomy of Breast (R/L/B)	Malignant Tumor of Breast/Year
PTCA	Prostatectomy (Prostate Cancer)	Nephrolithotomy (Kidney Stone Removal)
Splenectomy	Surgical Biopsy of Skin	Total Replacement of Hip (R/L/B)
Transplantation of Heart	NONE	Other: _____

Skin Disease History: (please circle all that apply, if cancer write the YEAR, if none circle NONE) -

Acne	Actinic Keratosis	Dry Skin
Dysplastic Nevus	Eczema	Hay Fever
Malignant Basal Cell	Malignant Melanoma	Psoriasis
Itchy Scalp	Squamous Cell Carcinoma	Sunburn (Blistering Sunburn)
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? (Please enter all allergies):

_____
_____

Social History:

Place of Residence: _____ **Do you feel safe at home (Y/N): ____** **Do you live alone (Y/N): ____**

Occupation: _____ **Employer: _____**

Cigarette Smoking:
Never Smoker
Former Smoker
Smokes Daily
Smokes Less than Daily

Do You Drive?
Drives in daytime Y/N
Drives at night Y/N

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

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

Alcohol Use:
No
Less than one drink per day
1-2 drinks per day
3 or more drinks per day

If you are 65 or older, please answer the following questions about alcohol use:

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? _____

Pharmacy: ***LOCAL PHARMACIES ONLY – NO MAIL ORDER***

Name: _____

Main Intersections: _____

Address: _____Zip Code: _____