ASSOCIATES IN DERMATOLOGY
Your Skin Cancer & Skincare Specialists

Patient Name: _____

Patient Account: _____

History and Intake Form

Past Medical History: Please **CHECK ALL** that apply.

- ☐ Adrenal Insufficiency
- ☐ Anemia/Thalassemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Auto-Immune Disease
  Specify: _____
- ☐ Bipolar Disorder
- ☐ Blood Clotting Disorder
- ☐ Bone Marrow Transplantation
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Deep Vein Thrombosis
- ☐ Depression
- ☐ Diabetes
- ☐ Easy Bruising
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Head Trauma
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ High Blood pressure
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lupus
- ☐ Lymphoma
- ☐ Malignant Hypertension
- ☐ Mental Health Hospitalization
- ☐ Neuromuscular Disorder
- ☐ Paralysis
- ☐ Pneumothorax
- ☐ Prostate Cancer
- ☐ Pulmonary Embolism
- ☐ Radiation Treatment
- ☐ Renal Disorder
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Severe Reaction to Anesthesia
- ☐ Stroke
- ☐ Trauma
- ☐ Valvular Heart Disease
- ☐ Vision Loss

NONE

Other: _____

Past Surgical History: Please **CHECK ALL** that apply.

- ☐ Appendix Removed
- ☐ Abdomen: Laparoscopy
- ☐ Abdomen: Laparotomy
- ☐ Abdominal Wall: Hernia Repair, Left Femoral
- ☐ Abdominal Wall: Hernia Repair, Left Inguinal
- ☐ Abdominal Wall: Hernia Repair, Right Femoral
- ☐ Abdominal Wall: Hernia Repair, Right Inguinal
- ☐ Abdominal Wall: Hernia Repair, Umbilical
- ☐ Abdominal Wall: Hernia Repair, Ventral
- ☐ Bladder Removed
- ☐ Brain: Brain Surgery for Cancer
- ☐ Brain: Brain Surgery for Trauma
- ☐ Breast Biopsy
- ☐ Breast: Lumpectomy
  - o Both Breasts
  - o Left Brest
  - o Right Breast
- ☐ Breast: Mastectomy
  - o Both Breasts
  - o Left Breast
  - o Right Breast
- ☐ Cesarean Section
- ☐ Colon: Colon Cancer Resection
- ☐ Colon: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Colon: Colostomy
- ☐ Esophagus: Esophagectomy
- ☐ Gallbladder Removed (Cholecystectomy)
- ☐ Heart: Biological Valve Replacement
- ☐ Heart: Coronary Artery Bypass
- ☐ Heart: Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Joint Replacement: Hip
  - o Both
  - o Left
  - o Right
- ☐ Joint Replacement: Knee
  - o Both
  - o Left
  - o Right
- ☐ Kidney Biopsy
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Kidney Removed
  - o Left
  - o Right
- ☐ Liver Removed
- ☐ Liver: Liver Transplant
- ☐ Liver: Shunt
- ☐ Lung: Left Upper Lobectomy

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- ☐ Lung: Left Pneumonectomy
- ☐ Lung: Left Lower Lobectomy
- ☐ Lung: Right Pneumonectomy
- ☐ Lung: Right Upper Lobectomy
- ☐ Lung: Right Middle Lobectomy
- ☐ Lung: Right Lower Lobectomy
- ☐ Ovaries Removed: Endometriosis
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Ovaries Removed: Ovarian Cyst
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate Biopsy
- ☐ Prostate Removed: Prostatectomy
- ☐ Prostate: TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Biopsy
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Small Bowel Resection
- ☐ Spine Surgery
- ☐ Spleen Removed
- ☐ Stomach: Gastrectomy
- ☐ Stomach: Gastrostomy
- ☐ Testicles Removed
- ☐ Uterus: Hysterectomy: Fibroids
- ☐ Uterus: Hysterectomy: Uterine Cancer
- ☐ Uterus: Hysterectomy: Cervical Cancer

NONE

Other: _____

Skin Disease History: Please **check all** that apply.

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ 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 ☐ No
If yes, what SPF? _____

Do you tan in a tanning salon? ☐ Yes ☐ No

Do you have a **family history** of Melanoma? ☐ Yes ☐ No
If yes, which relative(s)? _____

Do you have a health care proxy in the event you are unable to make your own medical decisions?
☐ **YES** ☐ **NO**

If YES, please provide the following:
Name: _____
Telephone number: _____

Do you have a living will?
☐ **YES** ☐ **NO**
If YES, which statement best reflects your wishes on advance care recommendations?

- ☐ Do Not Intubate
- ☐ Do Not Resuscitate
- ☐ Full Cardiopulmonary Resuscitation

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Plastic Surgery History: Please **CHECK ALL** that apply

- ☐ Abdomen: Abdominoplasty
- ☐ Abdomen: Abdomen Wall Reconstruction
- ☐ Body Contouring: Bachioplasty
- ☐ Body Contouring: Liposuction
- ☐ Body Contouring:
  - o Lower Body Lift
  - o Upper Body Lift
- ☐ Body Contouring: Thigh Lift
- ☐ Breast: Breast Augmentation
- ☐ Breast: Correction of Nipple Inversion
- ☐ Breast: Breast Lift
- ☐ Breast: Nipple Reconstruction
- ☐ Breast: Implant Removal
- ☐ Breast: Breast Reconstruction
- ☐ Breast: Breast Reduction
- ☐ Burn Wound Reconstruction
- ☐ Carpal Tunnel Release
- ☐ Chemical Peel
- ☐ Cleft Lip Repair
- ☐ Cleft Palate Repair
- ☐ Cubital Tunnel Release
- ☐ Decubitus Tunnel Release
- ☐ Dermabrasion
- ☐ Ears: Ear Reconstruction
- ☐ Ears: Earlobe Repair
- ☐ Ears: Otoplasty
- ☐ Face: Blepharoplasty
- ☐ Face:
  - o Lower Blepharoplasty
  - o Upper Blepharoplasty
- ☐ Face: Cheek Augmentation
- ☐ Face: Chin Argumentation
- ☐ Face: Brow Lift
- ☐ Face: Face Lift
- ☐ Face: Facial Fracture Repair
- ☐ Face: Face Reanimation
- ☐ Face: Frontoorbital Advancement
- ☐ Face: Frontal Sinus Fracture
- ☐ Face: Lefort Osteotomy
- ☐ Face: Mandible Fracture
- ☐ Face: Maxillary Fracture
- ☐ Face: Orbital Floor Fracture
- ☐ Face: Repair of Craniosynostosis
- ☐ Face: Zygoma Fracture
- ☐ Flap Reconstruction
- ☐ Hair Restoration
- ☐ Hand: Extensor Tendon Repair(s)
  - o Left Upper Extremity
  - o Right Upper Extremity
- ☐ Hand: Flexor Tendon Repair(s)
  - o Left Upper Extremity
  - o Right Upper Extremity
- ☐ Hand: Ganglion Cyst Removal
- ☐ Hand: Mallet Finger Repair
  - o Left Upper Extremity
  - o Right Upper Extremity
- ☐ Hand: Metacarpal Fracture Repair
- ☐ Hand: ORIF of Fracture
  - o Left Upper Extremity
  - o Right Upper Extremity
- ☐ Hand: Trigger Finger Release
  - o Left Upper Extremity
  - o Right Upper Extremity
- ☐ Hand: Phalangeal Fracture Repair
- ☐ Hand: Wrist Fracture Repair
- ☐ Laser Hair Removal
- ☐ Laser Resurfacing – CO2
- ☐ Laser Resurfacing – Erbium
- ☐ Nose: Rhinoplasty
- ☐ Nose: Septoplasty
- ☐ Orthopedic Hardware Coverage
- ☐ Scar Revision
- ☐ Skin Graft Reconstruction
- ☐ Sternal Wound Reconstruction
- ☐ Tendon Transfer
- ☐ Vascular Graft Coverage
- ☐ Wound Reconstruction

NONE

Other: _____

Breast Cancer History: Do you have a family history of breast cancer? ☐ YES ☐ NO

If so, which relative? _____

Malignant Hyperthermia and Anesthesia Sensitivity: Do you have a family history of malignant hyperthermia or severe reaction to anesthesia? ☐ YES ☐ NO

If so, which relative? _____

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Herbal Medications and Supplements: Please **CHECK ALL** that apply

- ☐ Anabolic Steroids
- ☐ Androstenedione
- ☐ Black Cohosh
- ☐ Cat's Claw
- ☐ Chondroitin
- ☐ Cranberry
- ☐ Echinacea
- ☐ Ephedra
- ☐ Evening Primrose
- ☐ Feverfew
- ☐ Fish Oil
- ☐ Flaxseed Oil
- ☐ Garlic
- ☐ Gingko Biloba
- ☐ Ginseng
- ☐ Glucosamine
- ☐ Goldenseal
- ☐ Green Tea
- ☐ Hawthorn
- ☐ HCG
- ☐ Horse Chestnut
- ☐ Human Growth Hormone
- ☐ Kava
- ☐ Licorice Root
- ☐ Mistletoe
- ☐ Peppermint
- ☐ Phentermine
- ☐ Red Clover
- ☐ Saw Palmetto
- ☐ St. John's Wort
- ☐ Valerian
- ☐ Vitamin A
- ☐ Vitamin B
- ☐ Vitamin C
- ☐ Vitamin D
- ☐ Vitamin E

NONE

Other _____

Medications: Please **enter all** current medications ☐ **NONE**

_____

_____

_____

Allergies: Please **enter all** allergies ☐ **NONE**

_____

_____

_____

Please check the following that apply

Smoking Status:
- ☐ Current every day smoker
- ☐ Former Smoker
- ☐ Never smoked

Alcohol Use:
- ☐ NONE
- ☐ Less than one alcoholic beverage a day
- ☐ 1-2 alcoholic beverages a day
- ☐ 3+ alcoholic beverages a day

Martial Status
- ☐ Single
- ☐ Married/In a relationship
- ☐ Divorced

Sexual Activity
- ☐ Not sexually active
- ☐ Sexually active with one partner
- ☐ Sexually active with more than one partner

Have you received the Flu shot this season? ☐ YES ☐ NO

Have you received the pneumonia vaccine? ☐ YES ☐ NO

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Family History (Only first degree relatives): _____

_____

Were you referred by a PHYSICIAN?

☐ YES ☐ NO

Physician Name: _____
Phone: _____
Reason for your visit today: _____

_____

Occupation: _____

Have you ever seen a Dermatologist? ☐ YES ☐ NO
If so Name: _____

PCP name: _____
Phone # _____
Fax#: _____

Name of Pharmacy: _____
Pharmacy # _____

ALERTS: Please **CHECK ALL** that apply

- ☐ Allergy to Adhesive
- ☐ Allergy to lidocaine
- ☐ Allergy to topical antibiotic s
- ☐ Artificial heart valve
- ☐ Artificial joints within past 2 years
- ☐ Blood thinners
- ☐ Defibrillator
- ☐ MRSA
- ☐ Pacemaker
- ☐ Require antibiotics prior to a surgical procedure
- ☐ Rapid heart beat with epinephrine
- ☐ Are you pregnant or currently trying to get Pregnant?
- ☐ History of Melanoma
- ☐ History of Vasovagal Response
- ☐ HIV Positive
- ☐ Breastfeeding
- ☐ Hepatitis B
- ☐ Hepatitis C

NONE

Are you currently experiencing any of the following?		
Symptom	**Yes**	**No**
*Problems with bleeding		
*Problems with healing		
*Problems with scarring		
rash		
immunosuppression		
Hay fever		
Anxiety		
Depression		
Fever or chills		
Night sweats		
Thyroid problems		
Sore throat		
Joint aches		
Muscle weakness		
headaches		
seizures		
Shortness of breath		
Chest Pain		
Blurry Vision		
Cough		
Wheezing		

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