DERMATOLOGY
& SKIN HEALTH OF DOTHAN

# HISTORY AND INTAKE FORM

**PATIENT NAME: _____** **DATE: _____**

**DATE OF BIRTH: _____**

**PAST MEDICAL HISTORY:** (Please check all that apply)

| | | | |
|---|---|---|---|
| Arthritis | | High Cholesterol | |
| Asthma | | HIV/AIDS | |
| Atrial fibrillation | | Kidney Disease | |
| Blood Clots | | Leukemia | |
| Bone Marrow Transplant | | Liver Disease | |
| Cancer (Specify Type): | | Lupus | |
| COPD or Emphysema | | Lymphoma | |
| Coronary Artery Disease/Heart Attack/ Heart Disease | | Multiple Sclerosis | |
| Crohn's Disease | | Seizures | |
| Depression | | Stroke | |
| Diabetes | | Tuberculosis | |
| Hay fever/Allergies | | Thyroid Disease | |
| High Blood Pressure | | Ulcerative Colitis | |
| History of COVID | | Other: | |

**PAST SURGICAL HISTORY:** (Please check all that apply)

| | | | |
|---|---|---|---|
| Coronary Artery Bypass | | Joint Replacement | |
| Heart Valve Replacement | | Hysterectomy | |
| Organ Transplant | | Bilateral Tubal Ligation | |

**SKIN DISEASE HISTORY:** (Please check all that apply)

| | | | |
|---|---|---|---|
| Acne | | Melanoma | |
| Actinic Keratosis (Pre-cancers) | | Psoriasis | |
| Basal Cell Skin Cancer | | Squamous Cell Skin Cancer | |
| Eczema | | Other: | |

**Do you wear Sunscreen?** ❑ YES ❑ NO **If yes, what SPF? _____ Do you tan in a tanning bed? ?** ❑ YES ❑ NO

**Do you have a history of melanoma in any of the following family members? (Please check all that apply)**

| | | | |
|---|---|---|---|
| Mother | | Brother | |
| Father | | Daughter | |
| Sister | | Son | |

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**MEDICATIONS:** *(Please list all prescription and over-the-counter medications)*

| | | |
|---|---|---|
| | | |
| | | |
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| | | |
| | | |
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| | | |
| | | |
| | | |

**MEDICATION ALLERGIES:** _____

**ALCOHOL USE:** (Please check the appropriate answer)

| | | | |
|---|---|---|---|
| None | | Less than one drink per day | |
| 1-2 drinks per day | | 3 or more drinks per day | |

**SMOKING STATUS:** (Please check the appropriate answer)

| | | | |
|---|---|---|---|
| Everyday | | Some days | |
| Former Smoker | | Never Smoked | |

**OCCUPATION** _____ **HOBBIES** _____

Do you have an advanced care plan/living will? ❑ YES ❑ NO

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**PATIENT NAME: _____**

**WHY ARE YOU SEEING THE DOCTOR? _____**

**HOW LONG HAVE YOU HAD THIS PROBLEM? _____**

| **Please check Yes or No** | **YES** | **NO** |
|---|---|---|
| Blood thinners *(including Aspirin, Ibuprofen, Aleve or Flomax)* | | |
| Bleeding disorder | | |
| Premedication prior to procedures | | |
| Artificial heart valve | | |
| Joint replacement within the past 2 years | | |
| HIV/AIDS | | |
| Hepatitis B or C | | |
| MRSA or recurrent skin infections | | |
| Allergy to lidocaine | | |
| Allergy to latex | | |
| Rapid heartbeat with epinephrine | | |
| Current smoker | | |
| Fainting | | |
| Pacemaker | | |
| Defibrillator | | |
| Other implanted device (stimulator) | | |
| Allergy to topical antibiotics | | |
| Allergy to adhesive | | |
| Immune suppression | | |
| Pregnant, planning a pregnancy, or breastfeeding | | |

Please list anything else you think your dermatologist may need to know:

_____

_____

_____

_____