



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	
Other:		

PAST SURGICAL HISTORY: (Please check all that apply)

Coronary Artery Bypass	Joint Replacement	
Heart Valve Replacement	Hysterectomy	
Organ Transplant	Bilateral Tubal Ligation	
Other:		

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	



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

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



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:
