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	
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	

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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

Are you interested in esthetic/cosmetic services? ❑ YES ❑ NO

If yes, would you like to receive promotional emails from our esthetician? ❑ 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:

_____

_____

_____

_____