

Patient Name: \_\_\_\_\_

**Dermatology and Skin Cancer Specialists, PSC**

**History and Intake Form**

**Past Medical History:** (please circle all that apply)

Anxiety	Coronary Artery Disease	Hyperthyroidism
Arthritis	Depression	Hypothyroidism
Artificial joints	Diabetes	Leukemia
Asthma	End Stage Renal Disease	Lung Cancer
Atrial fibrillation	GERD	Lymphoma
BPH	Hearing Loss	Pacemaker
Bone Marrow Transplantation	Hepatitis	Prostate Cancer
Breast Cancer	Hypertension	Radiation Treatment
Colon Cancer	HIV/AIDS	Seizures
COPD	Hypercholesterolemia	Stroke
		Valve Replacement
		None

Other \_\_\_\_\_

**Past Surgical History:** (please circle all that apply)

Appendix Removed	Kidney Biopsy
Bladder Removed	Kidney Removed (Right, Left)
Mastectomy (Right, Left, Bilateral)	Kidney Stone Removal
Lumpectomy (Right, Left, Bilateral)	Kidney Transplant
Breast Biopsy (Right, Left, Bilateral)	Ovaries Removed: Endometriosis
Breast Reduction	Ovaries Removed: Cyst
Breast Implants	Ovaries Removed: Ovarian Cancer
Colectomy: Colon Cancer Resection	Prostate Removed: Prostate Cancer
Colectomy: Diverticulitis	Prostate Biopsy
Colectomy: IBD	TURP
Gallbladder Removed	Skin Biopsy
Coronary Artery Bypass	Basal Cell Cancer Surgery
PTCA	Squamous Cell Carcinoma Surgery
Mechanical Valve Replacement	Melanoma Surgery
Biological Valve Replacement	Spleen Removed
Heart Transplant	Testicles Removed (Right, Left, Bilateral)
Joint Replacement, Knee (Right, Left, Bilateral)	Hysterectomy: Fibroids
Joint Replacement, Hip (Right, Left, Bilateral)	Hysterectomy: Uterine Cancer
Joint Replacement within last 2 years	None

Other \_\_\_\_\_

**Skin Disease History:** (please circle all that apply)

Acne	Eczema	Psoriasis
Actinic Keratoses	Flaking or Itchy Scalp	Squamous Cell Skin Cancer
Asthma	Hay Fever/Allergies	Cancer
Basal Cell Skin Cancer	Melanoma	None
Blistering Sunburns	Poison Ivy	
Dry Skin	Precancerous Moles	
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)? \_\_\_\_\_

**Cautions:** (please circle all that apply)

Do you have a pacemaker?    Yes    No

Do you have a defibrillator?    Yes    No

Have you had an artificial joint replacement?    Yes    No

If yes, when and what body locations? \_\_\_\_\_

Do you have an artificial heart valve?    Yes    No

Do you require antibiotics prior to a surgical procedure?    Yes    No

Do you have an allergy to adhesive?    Yes    No

Do you have an allergy to topical antibiotic ointments?    Yes    No

Are you on blood thinners?    Yes    No

Are you pregnant or currently trying to get pregnant?    Yes    No

Do you have an allergy to lidocaine?    Yes    No

Do you experience rapid heartbeat with epinephrine?    Yes    No

Do you get yeast infections with antibiotics?    Yes    No

Have you ever had difficulty stopping bleeding?    Yes    No

Do you have problems with healing?    Yes    No

Do you have problems with scarring? (hypertrophic or keloid)?    Yes    No

**Medications:** (Please enter all current medications)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medication Allergies:** (Please enter all allergies)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Social History:** (Please circle all that apply)

Currently Smokes  
Has smoked in the past  
Other \_\_\_\_\_

Drug Use  
None

**Review of Systems:** Are you currently experiencing any of the following?  
(please check yes or no for the following)

Symptom	Yes	No
Immunosuppression		
Changing Mole		
Rash		
Abdominal Pain		
Anxiety		
Bloody Stool		
Blurry Vision		
Chest Pain		
Cough		
Depression		
Fever or Chills		
Headaches		
Hay Fever		
Joint Aches		
Muscle Weakness		
Neck Stiffness		
Seizures		
Shortness of Breath		
Sore Throat		
Thyroid Problems		
Unintentional Weight Loss		
Wheezing		

Other Symptoms: \_\_\_\_\_

What is the reason for your visit? \_\_\_\_\_

Did a physician refer you to our office?

Yes No

If yes, who? \_\_\_\_\_