INNOVATIVE DERMATOLOGY

History and Intake Form

Patient Name:_____ **Date of Birth:**_____

Reason for visit:_____ **How did you hear about our office?:**_____

Were you referred here by a physician? Yes No **Referring physician:**_____

Your Pharmacy name: _____

Street:_____ Town/Zip code:_____

Past Medical History: (please circle all that apply)

Anxiety	Depression	Leukemia
Arthritis	Diabetes	Lung Cancer
Asthma	End Stage Renal Disease	Lymphoma
Atrial fibrillation	GERD	Prostate Cancer
Bone Marrow Transplantation	Hearing Loss	Radiation Treatment
BPH	Hepatitis	Seizures
Breast Cancer	High Blood pressure	Stroke
Colon Cancer	HIV/AIDS	Pacemaker
COPD	High Cholesterol	
Coronary Artery Disease	Thyroid Problems	NONE

Other _____

Past Surgical History: (please circle all that apply)

Appendix surgery	Kidney transplant
Breast surgery/biopsy (Right, Left, Both)	Liver transplant
Colon surgery	Ovarian surgery
Gallbladder surgery	Prostate surgery/biopsy
Cardiac Coronary Artery Bypass	Skin surgery (Melanoma, other skin cancers)
Cardiac transplant	Spleen surgery
Cardiac valve replacement (Biological, Mechanical)	Uterine surgery
Joint replacement (Hip, Knee)	
Kidney surgery/biopsy	NONE

Other _____

Medical ALERTS: (please circle all that apply)

Currently pregnant or trying to get pregnant	Immunosuppression
Hepatitis B or C	History of melanoma
Blood thinners	Requires antibiotics prior to a surgical procedure
Pacemaker	Rapid heartbeat with epinephrine
Defibrillator	Allergy to local numbing injections (lidocaine)
Artificial heart valve	Allergy to adhesive
Artificial joints within past 2 years	Allergy to topical antibiotics
Problems with scarring (keloid)	Allergy to latex

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Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
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

Family History: (please circle all that apply)

Melanoma	Mother	Father	Sister	Brother	Daughter	Son	Other
Other Skin Cancers	Mother	Father	Sister	Brother	Daughter	Son	Other
Diabetes	Mother	Father	Sister	Brother	Daughter	Son	Other
High Blood Pressure	Mother	Father	Sister	Brother	Daughter	Son	Other

Other _____

Medications: (please enter all current medications or "None")

_____
_____
_____

Allergies: (please enter all medication allergies or "None")

_____

Social History: (please circle all that apply)

Cigarette Smoking:
Never Smoked
Quit: Former Smoker
Smokes Less Than Daily
Smokes Daily

Alcohol Use
None
Less than 1 drink per day
1 to 2 drinks per day
3 or more drinks per day

Occupation:_____

Race:
White
Black/African American
Asian
American Indian or Native Alaskan
Other:_____

Ethnic Group:
Hispanic/Latino
Non-Hispanic/Latino

Patient Name:_____

Patient signature: _____ **Date:** _____