signature SPECIALTY CLINIC
BY MEMORIAL REGIONAL HEALTH
Dermatology

Dermatology History and Intake Form

Name _____ DOB_____ Age:_____

Who is your primary care provider? _____

Do you have a referral? ☐ Yes ☐ No

Who referred you? ☐ Self ☐ Other: _____

Past Medical History: (Please check all that apply)

- ☐ **None**
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Thyroid Problems
  - ☐ Hyper ☐ Hypo
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Pancreatic Cancer
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Scars
- ☐ Seizures
- ☐ Stroke
- ☐ Other: _____

_____

Past Surgical History: (Please check all that apply)

- ☐ **None**
- ☐ Appendix Removed
- ☐ Bladder Removed
- ☐ Mastectomy (Right, Left, Bilateral)
- ☐ Lumpectomy (Right, Left, Bilateral)
- ☐ Breast Biopsy (Right, Left, Bilateral)
- ☐ Breast Reduction
- ☐ Breast Implants
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Gallbladder Removed
- ☐ Coronary Artery Bypass
- ☐ Mechanical Valve Replacement
- ☐ Biological Valve Replacement
- ☐ Heart Transplant
- ☐ Joint Replacement, Knee (Right, Left, Bilateral)
- ☐ Joint Replacement, Hip (Right, Left, Bilateral)
- ☐ Joint Replacement within last 2 years
- ☐ Kidney Biopsy (Nephrectomy)
- ☐ Kidney Removed (Right, Left)
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Ovaries Removed: Endometriosis
- ☐ Ovaries Removed: Cyst
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Prostate Removed: Prostate Cancer
- ☐ Prostate Biopsy
- ☐ TURP (Prostate Removal)
- ☐ Spleen Removed
- ☐ Testicles Removed (Right, Left, Bilateral)
- ☐ Hysterectomy: Fibroids
- ☐ Hysterectomy: Uterine Cancer
- ☐ Other: _____

_____

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Skin Disease History: (Please check all that apply)

- ☐ **None**
- ☐ 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
- ☐ Other: _____

_____

- ☐ Family history of non-melanoma skin cancer
- ☐ Family history of melanoma

Do you use sunscreen? ☐ Yes ☐ No If yes, what SPF? _____

Do you tan in a tanning salon? ☐ Yes ☐ No

Medications and/or Supplements:

_____

_____

_____

☐ **None**

Drug Allergies:

_____

_____

_____

☐ **None**

Social History: (Please check all that apply)

Cigarette Smoking:

- ☐ Currently smokes, packs per day _____
- ☐ Have smoked in the past
- ☐ Never smoked

Alcohol Use:

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

Other medical family history (Only first degree relatives): _____

_____

Your occupation: _____

Preferred language: _____ Race: _____ Ethnic group: _____

What pharmacy do you use – City/State? _____

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Please check any of the following that apply:

- ☐ Problems with bleeding
- ☐ Problems with healing
- ☐ Problems with scarring
- ☐ Rash
- ☐ Immunosuppression
- ☐ Hay fever
- ☐ Chest pain
- ☐ Fever or chills
- ☐ Night sweats
- ☐ Unintentional weight loss
- ☐ Thyroid problems
- ☐ Sore throat
- ☐ Blurry vision
- ☐ Abdominal pain
- ☐ Bloody urine
- ☐ Joint aches
- ☐ Muscle weakness
- ☐ Neck stiffness
- ☐ Headaches
- ☐ Seizures
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Anxiety
- ☐ Depression
- ☐ Allergy to adhesive
- ☐ Allergy to lidocaine
- ☐ Allergy to topical antibiotic ointments
- ☐ Artificial joints within past two years
- ☐ Blood thinners
- ☐ Defibrillator
- ☐ MRSA
- ☐ Pacemaker
- ☐ Premedication to procedures
- ☐ Rapid heartbeat with epinephrine
- ☐ Pregnancy or planning pregnancy
- ☐ Other: _____

_____

Are you interested in cosmetic procedures? ☐ Yes ☐ No

If you are interested in any product or cosmetic promotions, please leave us your email address:

_____

Comments:

_____

_____

_____

_____

_____