HealthySkin History and Intake Form

Name: _____ Date of Birth: _____ Height: _____ Weight:_____

Occupation: **Hobbies:**

If you are a new patient, how were you referred to us? _____

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

Atrial fibrillation	Hepatitis B	Hyperthyroidism	Pacemaker	Seizures
Anxiety	Hepatitis C	Hypothyroidism	Defibrillator	Radiation Treatment
Diabetes	HIV/AIDS	Heart Attack	COPD	Rheumatoid Arthritis
End Stage Renal Disease	Hypertension	Stroke	Hearing Loss	GERD
Depression	Asthma	High Cholesterol	BPH	Coronary Artery Disease

History of Cancer (Other Than Skin Cancer): _____ None

Do you have any issues with: (*Please circle all that apply)* Healing Bleeding Scarring Immunosuppression

Do you have any allergies/sensitivities to the following? : Adhesives Latex Lidocaine Epinephrine Neosporin/Bacitracin

YOUR Skin Disease History: *(Please circle all that apply*)

Basal Cell Skin Cancer Precancerous Spots/Moles Actinic Keratoses

Squamous Cell Skin Cancer Melanoma - Location:_____ Year:_____

YOUR FAMILY History of Skin Disease: *(Please circle all that apply)*

Basal Cell Skin Cancer Squamous Cell Skin Cancer Melanoma Yes, skin cancer type unknown

If you do have family history, which family member? _____

Do you wear sunscreen? Yes No **Do you tan in a tanning salon? Yes No Not anymore**

If yes, what SPF? _____

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

Heart Valve Replacement Joint Replacement - Site and year:_____

Coronary Artery Bypass Organ or Bone Marrow Transplant:_____

Please list additional surgeries and their approximate date: _____

_____

Females Only, Are You: Pregnant Breastfeeding

Medications: *Please list all current medications/vitamins/herbs, including the dosage, how often you take them, and how (ex: by mouth, etc). If more space is required, please see our Front Desk for a separate Medication Form.*

_____

_____

_____

Allergies: *Please list all allergies and the reaction you experience to each.*

_____

_____

Cigarette Smoking:	**Alcohol Use:**		**Substance Abuse:**
Never smoked	Yes	# of Drinks Per Day:_____	Yes
Quit: former smoker	No		No
Smokes less than daily			
Smokes daily			

Is it ok to leave a detailed message with anyone else in your household? No Yes, _____

Pharmacy: _____ **Cross Streets:** _____

Zip code: _____ _____