Three Rivers Dermatology Intake Form

Patient Name: **Date of Birth:** **Today's Date:**

Past Medical History (please circle all that apply)

Anxiety	Depression	Hyper or Hypothyroid
Arthritis	Diabetes	Leukemia
Asthma	End Stage Renal Disease	Lung Cancer
Atrial Fibrillation	GERD/Reflux	Lymphoma
Bone Marrow Transplant	Hearing Loss	Prostate Cancer
Breast Cancer	Hepatitis (type)	Radiation Treatment
Colon Cancer	High Blood Pressure/Hypertension	Seizures
COPD	HIV/AIDS	Stroke
Coronary Artery Disease	High Cholesterol	None of the above
Other:		

Past Surgical History (please circle all that apply)

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

Skin Disease History (please circle all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratoses	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	None of the above
Other:		

Do you wear sunscreen? Yes No If yes, what SPF? _____
Tan in a tanning salon? Yes No
Family history of Melanoma? Yes No If yes, which relative(s)? _____

Smoking?: Daily Occasionally Never
Alcohol?: # of drinks each day?_____I do not drink -How many times in the past year have you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women or any adult older than 65? 0-1, or 2 or more?
Recreational Drug Use? Yes No
Occupation:_____Retired? Yes No
Any first degree relatives (parent, sibling, or child) with a history of other skin cancer? Yes No If yes, which relative(s)? _____

Medications (include herbals and supplements): Name Dose Frequency
Allergies:

(please complete both sides)

Other Family History (first degree relatives only):_____

Did you get the flu shot? Y/N Shingles vaccine? Y/N Pneumonia vaccine? Y/N Do you have a living will? Y/N

Would you prefer to be contacted by phone or email?_____May we leave you a detailed message? Y/N

Preferred pharmacy:_____Pharmacy phone #:_____Pharmacy City or Zip Code:_____

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

Symptom	Yes	No
Rash?		
Changing moles?		
Dry skin?		
Problems with healing?		
Problems with bleeding?		
Problems with scarring?		
Depression?		
Anxiety?		
Mood changes?		
Abdominal pain?		
Bloody stools?		
Diarrhea?		
Joint or muscles aches?		
Headaches?		
Blurry vision?		
Fever or chills?		
Night sweats?		
Unintended weight loss?		
Enlarged lymph nodes?		

Other Symptoms: _____

ALERTS: (please circle all that apply)

Allergy to adhesive
Allergy to lidocaine
Allergy to topical antibiotics
Artificial heart valve
Artificial joint replacement within the past 2 years
Blood thinners such as aspirin, vitamin E, or Coumadin?
Defibrillator
Immunosuppression
MRSA
Organ Transplant
Pacemaker
Require antibiotics prior to a surgical procedure
Rapid heart beat with epinephrine
Are you pregnant or currently trying to get pregnant?

If you have been seen here previously, since your last visit, have you had any:
New health problems or surgical procedures? Yes No (If yes, please explain)

_____

_____

Changes in your medications or been diagnosed with new allergies? Yes No (If yes, please explain)

_____

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