THREE RIVERS DERMATOLOGY

Intake Form

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

Past Medical History (please check 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 check 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 check 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 a flu shot? ❑ YES ❑ NO *If over 65: Pneumonia vaccination?* ❑ YES ❑ NO

Did you get the Shingrix shot (Shingles Vaccine) ❑ YES ❑ NO Do you have a living will? ❑ YES ❑ NO

Would you prefer to be contacted by ❑ Phone or ❑ email? May we leave you a detailed message? ❑ YES ❑ NO

PREFERRED PHARMACY:_____PHARMACY CITY OR ZIP CODE:_____

PHARMACY PHONE NUMBER :_____

Review of Symptoms: Are you currently experiencing any of the following? (please check all that apply)

❑ Rash	❑ Bloody Stools
❑ Changing Moles	❑ Diarrhea
❑ Dry Skin	❑ Joint or Muscle Aches
❑ Problems With Healing	❑ Headaches
❑ Problems With Bleeding	❑ Blurry Vision
❑ Problems With Scarring	❑ Fever or Chills
❑ Depression	❑ Night Sweats
❑ Anxiety	❑ Unintended Weight Loss
❑ Mood Changes	❑ Enlarged Lymph Nodes
❑ Abdominal Pain	❑ Other Symptoms:_____

Alerts: (Please check all that apply)

❑ Allergy to Adhesive	❑ Immunosuppression
❑ Allergy to Lidocaine	❑ MRSA
❑ Allergy to Topical Antibiotics	❑ Organ Transplant
❑ Artificial Heart Valve	❑ Pacemaker
❑ Artificial Joint Replacement within the past 2 years	❑ Require Antibiotics Prior to a Surgical Procedure
❑ Blood Thinners such as Aspirin, Vitamin E, or Coumadin	❑ Rapid Heart Beat with Epinephrine
❑ Defibrillator	❑ You Are Pregnant or are 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)

_____