



Damon McClain, MD, FAAD Susannah Berke, MD, FAAD Molly McIntyre, PA-C, MMS, MPH Leah Greco, PA-C

Medical History and Intake

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

Skin History (please check all that apply)

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

Do you wear sunscreen? YES NO
 How often? _____
 SPF? _____

Use a tanning bed? NEVER PAST CURRENT

Does anyone in your family have a history of Melanoma? YES NO
 If yes, which relative? _____

1st degree relatives (parents, siblings, children) with a history of other skin cancer? YES NO
 If yes, which relative and type of cancer? _____

Are you currently experiencing any of the following symptoms?

- | | | |
|-------------------------------------------------|-------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Rash | <input type="checkbox"/> Depression | <input type="checkbox"/> Blurry Vision |
| <input type="checkbox"/> Changing Moles | <input type="checkbox"/> Mood Changes | <input type="checkbox"/> Fever or Chills |
| <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Problems with healing | <input type="checkbox"/> Bloody Stool | <input type="checkbox"/> Unintentional Weight Gain |
| <input type="checkbox"/> Problems with bleeding | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Unintentional Weight Loss |
| <input type="checkbox"/> Problems with scarring | <input type="checkbox"/> Joints or Muscle Aches | <input type="checkbox"/> Enlarged Lymph Nodes |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Headaches | <input type="checkbox"/> Other: _____ |

Occupation: _____

Medications: please include the name, dose, and frequency

Allergies:

Pharmacy: _____
 City/Zip Code: _____

Do you drink alcohol? YES NO
 Do you use tobacco? YES NO
 Recreational drug use? YES NO



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PAST MEDICAL HISTORY (Please check all that apply):

- | | | |
|--------------------------------------------------|--------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> Lung Cancer |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> GERD/Reflux | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Bone Marrow Transplant | <input type="checkbox"/> Hepatitis [type ____] | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> COPD | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> None of the above |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hypothyroidism | |

PAST SURGICAL HISTORY (Please check all that apply):

- | | | |
|------------------------------------------------------|---------------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Appendix Removed | <input type="checkbox"/> Coronary Artery Bypass | <input type="checkbox"/> Kidney Stone Removal |
| <input type="checkbox"/> Bladder Removed | <input type="checkbox"/> Gallbladder Removed | <input type="checkbox"/> Kidney Transplant |
| <input type="checkbox"/> Mastectomy [right, left] | <input type="checkbox"/> Mechanical Valve Replacement | <input type="checkbox"/> Spleen Removed |
| <input type="checkbox"/> Lumpectomy [right, left] | <input type="checkbox"/> Biological Valve Replacement | <input type="checkbox"/> Prostate Biopsy |
| <input type="checkbox"/> Breast Reduction | <input type="checkbox"/> Heart Transplant | <input type="checkbox"/> Prostate Removed |
| <input type="checkbox"/> Breast Biopsy [right, left] | <input type="checkbox"/> Knee Replacement [right, left] | <input type="checkbox"/> Vasectomy |
| <input type="checkbox"/> Breast Implants | <input type="checkbox"/> Hip Replacement [right, left] | <input type="checkbox"/> Testicles Removed |
| <input type="checkbox"/> Colectomy | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Kidney Biopsy | <input type="checkbox"/> None of the above |
| <input type="checkbox"/> Ovaries Removed | <input type="checkbox"/> Kidney Removed [right, left] | |

ALERTS (Please check all that apply):

- | | |
|------------------------------------------------------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> Allergy to Adhesive | <input type="checkbox"/> Defibrillator |
| <input type="checkbox"/> Allergy to Lidocaine | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Allergy to Topical Antibiotics | <input type="checkbox"/> Require Antibiotics Prior to Surgery |
| <input type="checkbox"/> Rapid Heart Rate with Epi | <input type="checkbox"/> MRSA |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Immunosuppression |
| <input type="checkbox"/> Artificial Joint Replacement | <input type="checkbox"/> Organ Transplant |
| <input type="checkbox"/> Blood Thinner [Aspirin, Vitamin E, Coumadin] | <input type="checkbox"/> Pregnant or Breastfeeding |