



Name \_\_\_\_\_

Chart# \_\_\_\_\_

# Eastern Dermatology & Pathology

## HISTORY AND INTAKE FORM

### Past Medical History: (please circle all that apply)

- |                             |                         |                     |
|-----------------------------|-------------------------|---------------------|
| Anxiety                     | Depression              | Leukemia            |
| Arthritis                   | Diabetes                | Lung Cancer         |
| Asthma                      | End Stage Renal Disease | Lymphoma            |
| Atrial fibrillation         | GERD                    | Prostate Cancer     |
| Bone Marrow Transplantation | Hearing Loss            | Radiation Treatment |
| Breast Cancer               | Hepatitis               | Seizures            |
| Colon Cancer                | High Blood pressure     | Stroke              |
| COPD                        | HIV/AIDS                | NONE                |
| Coronary Artery Disease     | High Cholesterol        |                     |
|                             | Thyroid Problems        |                     |

Other \_\_\_\_\_

### Past Surgical History: (please circle all that apply)

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

Other \_\_\_\_\_

**Skin Disease History:** (please circle all that apply)

Acne	Eczema	Psoriasis
Actinic Keratoses	Flaking or Itchy Scalp	Squamous Cell Skin Cancer
Asthma	Hay Fever/Allergies	
Basal Cell Skin Cancer	Melanoma	
Blistering Sunburns	Poison Ivy	NONE
Dry Skin	Precancerous Moles	

Other \_\_\_\_\_

Do you wear Sunscreen? Yes No

If yes, what SPF? \_\_\_\_\_

Do you tan in a tanning salon? Yes No

Do you have a family History of Melanoma? Yes No

If yes, which relative(s)? \_\_\_\_\_

**Alerts:** (please circle all that apply)

Have you ever had difficulty-stopping bleeding? Yes No

Do you require antibiotics prior to a surgical procedure? Yes No

Have you had an artificial joint replacement? Yes No

If yes, when and what body locations? \_\_\_\_\_

Do you have an artificial heart valve? Yes No

Do you have a pacemaker? Yes No

Do you have a defibrillator? Yes No

Are you pregnant or currently trying to get pregnant? Yes No

**Medications:** (please enter all current medications)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies:** (please enter all allergies)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Social History:** (please circle all that apply)

**CIGARETTE SMOKING:**

Currently Smokes  
Has Smoked in the Past  
Never Smoked  
Former Smoker

**ALCOHOL USE:**

EtOH - None  
EtOH - Less Than 1 Drink Per Day  
EtOH - 1-2 Drinks Per Day  
EtOH - 3 or More Drinks Per Day

Other \_\_\_\_\_

Preferred Language: \_\_\_\_\_

Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Preferred Pharmacy Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

City or Zip Code: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_