Name _____

Chart# _____

Eastern Dermatology & Pathology

HISTORY AND INTAKE FORM

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrilation
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
High Blood pressure
HIV/AIDS
High Cholesterol
Thyroid Problems
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke

NONE

Other _____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy (Nephrectomy)
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed; Endometriosis
Ovaries Removed: Cyst
Ovaries Removed; ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP (Prostate Removal)
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer

NONE

Other _____

Skin Disease History: (please circle all that apply)

Acne	Eczema	Psoriasis
Actinic Keratoses	Flaking or Itchy Scalp	Squamous Cell Skin
Asthma	Hay Fever/Allergies	Cancer
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: _____