DERMASURGERY CENTER, P.C.

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History and Intake Form

NAME: _____ DATE OF BIRTH:_____

Birthplace (City & State): _____

Preferred Pharmacy: _____ Phone: _____
Street:_____ City:_____ Zipcode:_____

Preferred Language: _____

Race: (Check one)

- ☐ American Indian/ Alaska Native
- ☐ Asian
- ☐ Black / African American
- ☐ Native Hawaiian / Pacific Islander
- ☐ White
- ☐ Other Race

Ethnicity: (Check one)

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Other: _____

Past Medical History: **(please check all that apply)**

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ BPH
- ☐ Cerebrovascular accident
- ☐ Chronic obstructive lung disease
- ☐ Coronary arteriosclerosis
- ☐ Depressive disorder
- ☐ Diabetes mellitus
- ☐ Disease caused by 2019-nCoV
- ☐ Elevated blood pressure
- ☐ End-stage renal disease
- ☐ Epilepsy
- ☐ Gastrooesophageal reflux disease
- ☐ Hypertension
- ☐ Hearing loss
- ☐ HIV
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Inflammatory disease of liver
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Malignant tumor of lung
- ☐ Malignant tumour of breast
- ☐ Malignant tumour of colon
- ☐ Malignant tumour of prostate
- ☐ Radiation therapy treatment
- ☐ Transplantation of bone marrow
- ☐ Other_____
- ☐ **None**

Past Surgical History: **(please check all that apply)**

- ☐ Abdominoperineal resection
- ☐ Biopsy of breast
- ☐ Biopsy of prostate
- ☐ Coronary artery bypass graft
- ☐ Excision of basal cell carcinoma
- ☐ Excision of melanoma
- ☐ Excision of squamous cell carcinoma
- ☐ History of **appendectom**y
- ☐ History of **cholecystectomy**
- ☐ History of **colectomy**
- ☐ History of **colostomy**
- ☐ History of **liver excision**
- ☐ History of **coronary angioplasty**
- ☐ History of **heart valve replacement**
- ☐ History of **prostatectomy**
- ☐ History of **total cystectomy**
- ☐ History of **tubal ligation**
- ☐ Hysterectomy
- ☐ Kidney biopsy
- ☐ Kidney stone removal
- ☐ Kidney transplant
- ☐ Low anterior resection of rectum
- ☐ Lumpectomy of breast
  Left____ Right____ Both ____
- ☐ Mastectomy of breast
  Left____ Right____ Both ____
- ☐ Mechanical heart valve replacement
- ☐ Oophorectomy
- ☐ Pancreatectomy
- ☐ Portosystemic shunt operation
- ☐ Prostatectomy
- ☐ Prosthetic arthroplasty of bilateral hips
- ☐ Splenectomy
- ☐ Surgical biopsy of skin
- ☐ Total nephrectomy
- ☐ Total orchidectomy
- ☐ Total replacement of hip
  Left____ Right____ Both____
- ☐ Total replacement of knee
  Left___ Right____ Both____
- ☐ Transplantation of heart
- ☐ Transplantation of liver
- ☐ Other_____
- ☐ **None**

Skin Disease History: (please check all that apply)

- ☐ Acne
- ☐ Actinic keratosis
- ☐ Asteatosis cutis
- ☐ Basal cell carcinoma of skin
- ☐ Contact dermatitis due to poison ivy
- ☐ Dysplastic nevus of skin
- ☐ Eczema
- ☐ Hay fever
- ☐ Malignant melanoma
- ☐ Pruritus of scalp
- ☐ Psoriasis
- ☐ Squamous cell carcinoma
- ☐ Sunburn of second degree
- ☐ Other_____
- ☐ **None**

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)? _____

Any **other** family history of cancers: _____

Social History: **(Please check all that apply)**

Smoking Status

- ☐ Current every day smoker
- ☐ Current some day smoker (tobacco)
- ☐ Current some day smoker (cigarette)
- ☐ Former smoker
- ☐ Never smoker
- ☐ Smoker, current status unknown
- ☐ Cigar Smoker

Start Smoking:_____
Quit Smoking:_____
Packs per day_____
Years Smoking:_____

Alcohol Use

- ☐ None
- ☐ Less than 1 drink a day
- ☐ 1-2 Drinks a day
- ☐ 3 or more drinks a day

Sexual History

- ☐ Not sexually active
- ☐ Sexually active with one partner
- ☐ Sexually active with more than one partner
- ☐ LGBTQ

Illicit Drug Use

- ☐ Drug Use
- ☐ IV drug use
- ☐ No drug use

Safety

- ☐ I feel safe at home
- ☐ I do not feel safe at home

Exercise

- ☐ Several times a day
- ☐ Once a day
- ☐ Few times a week
- ☐ Few times a month
- ☐ Never

Caffeine Use

- ☐ Several Times a day
- ☐ Once a day
- ☐ Few times a week
- ☐ Few times a month
- ☐ Never

Driving Habits

- ☐ Drives in Daytime
- ☐ Drives at night

Occupation and Workplace: _____

Medications: (Please detail all medications including the **dosage and frequency**)

_____
_____
_____
_____

Allergies: (Please enter all allergies **AND REACTIONS!)** _____
_____

- ☐ **No known allergies (NKA)**

Review of Systems: Are you currently experiencing any of the following?

Symptom	Yes	No
problems with bleeding		
Problems with healing		
Problems with scarring (hypertrophic or keloid)		
Rash		
Immunosuppression		
Hay fever		
Chest pain		
Fever or chills		
Night sweats		
Unintentional weight loss		
Thyroid problems		
Sore throat		
Blurry vision		
Abdominal pain		
Bloody stools		
Bloody urine		
Joint aches		
Muscle weakness		
Neck stiffness		
Headaches		
Seizures		
Cough		
Shortness of breath		
Wheezing		
Anxiety		
Depression		

Other: _____

Alerts:

Symptom	Yes	No
Transplant Recipient		
Allergy to adhesive		
Allergy to lidocaine		
Allergy to topical antibiotic ointment		
Artificial heart valve		
Artificial joints within past two years		
Blood thinners (not aspirin)		
Defibrillator		
MRSA		
Pacemaker		
Premedication prior to surgical procedures (NOT DENTAL)		
Rapid heartbeat with epinephrine		
Pregnancy or planning pregnancy		
Hepatitis C		
West Africa: Travel or Contact		
Ebola Risk		

Other: _____