DEL MAR DERMATOLOGY **DATE**_____

HISTORY AND INTAKE FORM

NAME_____ DOB_____

PAST MEDICAL HISTORY (PLEASE CIRCLE ALL THAT APPLY)

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

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
Gallbladder removed
Coronary Artery Bypass
Mechanical Valve Replacement
Biological Valve Replacement
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 Removed
Kidney Transplant
Ovaries Removed: Endometriosis, Cyst, Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP (Prostate Removal)
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer

NAME_____

SKIN DISEASE HISTORY: (PLEASE CIRCLE ALL THAT APPLY)

Acne	Dry Skin	Poison Ivy
Actinic Keratosis	Eczema	Precancerous Moles
	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Blistering Sun Burns
Squamous Cell Skin Cancer	Melanoma	

OTHER:

_____
_____
_____

Have you had pneumococcal immunization ? yes/no Date_____ (month/year)

Have you had influenza (flu) immunization? yes/no Date_____ (month/year)
If not, reason?_____

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) ?_____

Do you have a family history of Basal Cell Skin Cancer? YES NO
If yes, which relative(s)?_____

Do you have a family history of Squamous Cell Skin Cancer? YES NO
If yes, which relative(s)?_____

Medications: (Please enter all current medications and doses, strengths, times per day)

_____
_____
_____

Allergies: (Please enter all allergies or N/A)

_____
_____
_____

Family Medical History (Only immediate relative)

_____
_____
_____

NAME_____

SOCIAL HISTORY (PLEASE CIRCLE ALL THAT APPLY)

Cigarette Smoking:

Currently smokes
Has smoked in the past
Never smoked
Former smoker

Alcohol Use:

None
Less than 1 drink per day
1-2 drinks per day
3 or more drinks per day

FOR MEN:
How many times in the past year have you had 5 or more drinks in a day? _____

FOR WOMEN AND ADULTS OLDER THAN 65:
How many times in the past year have you had 4 or more drinks in a day? _____

May we download medications from your pharmacy? YES NO

If not provided at registration, please list the pharmacy here.

_____

NAME_____

REVIEW OF SYSTEMS: Are you currently experiencing any of the following?
(Please check yes or no for the following)

SYMPTOM	YES	NO
Immunosuppression		
Unintentional Weight Loss		
Fever or Chills		
Night Sweats		
Chest Pain		
Headaches		
Cough		
Shortness of Breath		
Wheezing		
Joint Aches		
Hayfever		
Rash		
Problems with Healing		
Problems with Scarring		
Problems with Bleeding		
Thyroid Problems		
Sore Throat		
Blurry Vision		
Abdominal Pain		
Blood Stool		
Bloody Urine		
Muscle Weakness		
Neck Stiffness		
Seizures		
Anxiety		
Depression		

Are you in any pain today? (circle) 0 1 2 3 4 5
Symptoms_____

Alerts: (Please circle all that apply)

Allergy to adhesive Allergy to Lidocaine Allergy to topical antibiotics Artificial Heart Valve
Artificial joint replacement Blood Thinners Defibrillator MRSA Pacemaker
Require antibiotics prior to a surgical procedure Rapid heart beat with epinephrine

Are you pregnant or currently trying to get pregnant?