DERMATOLOGY ASSOCIATES, P.C.

PATIENT HISTORY AND INTAKE FORM

Patient name: ___________________________________ Date of Birth: ____________________

Pharmacy name & location: ____

Primary Care Physician: ____

PAST MEDICAL HISTORY

(Please circle all that apply)

ANXIETY	DEPRESSION	HYPOTHYROID
ARTHRITIS	DIABETES	LEUKEMIA
ASTHMA	END STAGE RENAL DISEASE	LUNG CANCER
ATRIAL FIBRILLATION	GERD	LYMPHOMA
BONE MARROW TRANSPLANT	HEARING LOSS	PROSTATE CANCER
BHP	HEPATITIS	RADIATION TREATMENT
BREAST CANCER	HYPERTENSION	SEIZURES
COLON CANCER	HIV/AIDS	STROKE
COPD	HYPERCHOLESTEROLEMIA	NONE
CORONARY ARTERY DISEASE	HYPERTHYROID	

PAST SURGICAL HISTORY

(Please circle all that apply with explanation of procedure if applicable)

APPENDIX _______________	OVARIES _______________	JOINT REPLACEMENT
BLADDER ________________	PANCREAS _____________	________________________
BREAST _________________	PROSTATE _____________	HEART VALVE
COLON __________________	SKIN ___________________	________________________
GALLBLADDER ___________	SPLEEN ________________	HEART ________________
TESTICLES ______________	KIDNEY ________________	UTERUS _______________
LIVER ___________________	NONE/OTHER __________________	

SKIN DISEASE HISTORY

(Please circle all that apply)

ACNE	ECZEMA	PRECANCEROUS MOLE
ACTINIC KERATOSES	FLAKING OR ITCHING SCALP	PSORIASIS
BASAL CELL CARCINOMA	HAYFEVER/ALLERGIES	SQUAMOUS CELL CARCINOMA
BLISTERING SUNBURN	MELANOMA	DRY SKIN
POISON IVY	NONE	

OTHER ____

Do you wear sunscreen? YES NO

If yes, what SPF? ____

Do you use a tanning salon? YES NO

PLEASE COMPLETE BACK OF THIS FORM

Do you have a family history of melanoma? YES NO

If yes, which relative(s)? ____

Any other family history? ____

MEDICATIONS
(Please include dosage amount and frequency of use)

____________	____________	____________
____________	____________	____________
____________	____________	____________
____________	____________	____________

ALLERGIES TO MEDICATION
(Please list medications only)

____________	____________	____________
____________	____________	____________

SOCIAL HISTORY
(Please circle all that apply)

Cigarette Smoking:
- Never smoked
- Quit: Former smoker
- Smokes less than daily
- Smokes daily

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

International travel within the last six months: ________________________________

IS IT OKAY TO LEAVE A DETAILED MESSAGE FOR YOU? YES _____ NO _____

PLEASE PROVIDE THE BEST NUMBER TO REACH YOU. ________________________