LAKEWOOD DERMATOLOGY

Intake and History Form

Name: _____ Date: _____

Street Address: _____ City / State: _____

Zip Code: _____ Date of Birth: _____ Gender: _____

Phone Number (mobile): _____ Phone Number (home):_____

Email Address: _____

Emergency Contact: _____

Preferred Language: _____ Race: _____

How did you hear about us (please circle all that apply):

Lakewood Advocate Ad | Lake Highlands Advocate Ad

ZocDoc | Referral from Physician (please specify physician):_____

Friend/Family Member | Google Search

Other (please specify):_____

Preferred Pharmacy

Name: _____

Phone Number: _____

City or Zip Code: _____

Past Medical History

Select any of the following medical conditions you currently have:

- ☐ Asthma
- ☐ Bone Marrow Transplant
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ Hepatitis (Liver Disease)
- ☐ Hypertension
- ☐ HIV / AIDS
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Transplanted organs
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Sarcoid
- ☐ Sjogren's
- ☐ Any other cancers: Please Specify

_____

_____

_____

- ☐ NONE
- ☐ Other History:

_____

_____

_____

Past Surgical History

Please list any surgeries?

_____
_____
_____
_____
_____
_____

Skin Disease History

Have you had any of the following?

- ☐ Basal Cell Skin Cancer
- ☐ Eczema
- ☐ Melanoma
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ NONE
- ☐ Other Skin Cancer or Skin Condition:

_____
_____

Do you wear Sunscreen?

◯ Yes ◯ No

If yes, what SPF? _____

Do you tan or have you ever tanned in a tanning salon?

◯ Yes ◯ No

Do you have a family history of Melanoma?

◯ Yes ◯ No

If yes, which relative?

_____
_____

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Medications

List all current medications:

_____
_____
_____

Allergies

List all medication allergies and type of reaction if known:

_____
_____
_____

Social History

Smoking Status (please choose one):

- ☐ Current every day smoker
- ☐ Current some days smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Unknown if ever smoked

Start Smoking:

- mm/dd/yyyy _____

Quit Smoking:

- mm/dd/yyyy _____

Number of Packs Per Day: _____

Total Years Smoking: _____

Occupation and any exposure to chemicals:

_____
_____

Family History of Skin Cancer or Skin Conditions

Please include only first-degree relatives (Mother, Father, Siblings, Children):

_____
_____
_____

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Review of Systems

Please check yes or no if you are experiencing any of the following:

Symptom	Yes	No
Rash		
Immunosuppression		
Joint Aches		
Problems with Bleeding		
Problems with Scarring		
Unintentional Weight Loss		
Thyroid Problems		
Sore Throat		
Blurry Vision		
Muscle Weakness		
Chest Pain		
Abdominal Pain		
Bloody Urine		
Seizures		
Shortness of Breath		
Anxiety		
Depression		

Alerts

Please check yes or no for the following conditions:

Symptom	Yes	No
HIV		
Current or Past Cancers		
On Chemotherapy within the last year		
Transplanted Organ		
On Immunosuppressing Medications within the last year		
Problems with Immune System		
Allergy to Lidocaine		
Artificial Heart Valve		
Artificial Joint placed within the past 2 years		
Defibrillator		
MRSA		
Pacemaker		
Currently Pregnant or Planning on becoming Pregnant		