Total Dermatology Care Center

History and Intake Form

Name: _____

Preferred Language: _____

Primary Care Doctor: _____

Preferred Pharmacy: _____

Pharmacy Phone #: _____ Pharmacy Zip Code: _____

What is the reason for your visit? Skin cancer screening Rash Acne

Other: _____

Skin Disease History

Have you had skin cancer? Please include type, year, and location on body. _____

_____

Do you have a family history of Melanoma? _____

Past Medical History (Please Circle all that apply)

Anxiety	Depression	Hypothyroidism
Arthritis	Diabetes	Hyperthyroidism
Asthma	GERD	Benign Prostatic Hyperplasia
Atrial Fibrillation	Abnormal Rhythm	Lymphoma
Bone Marrow Transplantation	Hearing Loss	Prostate Cancer
BPH	Hepatitis	Radiation Treatment
Breast Cancer	Hypertension	Seizures
Colon Cancer	HIV/AIDS	Stroke
COPD	Hypercholesterolemia	Coronary Artery Disease

Any other type of cancer (type, year, treatment) _____

Other: _____

_____

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Past Surgical History (Please Circle all that apply)

Appendix	Hip or knee Replacement	Heart Valve Replacement
Gallbladder	Prostate surgery	Heart/Kidney/Liver Transplant
Mastectomy	Hysterectomy (uterus)	Oopherectomy (ovaries)

Other: _____

_____

Medications (Please list all current medications)

_____

_____

_____

_____

_____

Please list all allergies (and type of reaction):

_____

_____

Social History

Tobacco: Never Smoked Former Smoker Smoker some days Every day smoker

Alcohol: None 1 to 2 drinks per day 3 or more drinks a day

Drug use IV drug use

Alerts: Do you have any of the following? (Please circle)

Allergy to: Adhesive Latex Lidocaine

Pacemaker Defibrillator Require premedication before procedures