Dermatology Intake Form

DERMATOLOGY MEDICAL HISTORY FORM (7-4-17)

Name: _____ **Age:** _____

DOB: _____ dd / mm / yyyy **Prefer to be called:** _____

Height: _____ **Weight:** _____

Did a doctor recommend that you see a dermatologist?

◯ No ◯ Yes

For my prescription medications, I prefer

◯ Brand only ◯ Generic only ◯ Either Brand or Generic would be fine

GENERAL MEDICAL HISTORY: DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Pacemaker or defibrillator

◯ Y ◯ N

Acne &/ or Rosacea

◯ Y ◯ N

HIV or AIDS

◯ Y ◯ N

Asthma

◯ Y ◯ N

Overgrown scars or keloids

◯ Y ◯ N

Hepatitis (what type?) A B C

◯ Y ◯ N

Hayfever, seasonal allergies

◯ Y ◯ N

Kidney problems (what type?)

◯ Y ◯ N

Liver cirrhosis or other liver problems

◯ Y ◯ N

Eczema

◯ Y ◯ N

Epilepsy or seizures

◯ Y ◯ N

Herpes-(circle) genital or mouth

◯ Y ◯ N

Psoriasis

◯ Y ◯ N

Crohn's disease or ulcerative colitis

◯ Y ◯ N

Genital warts

◯ Y ◯ N

Diabetes, controlled with (circle): diet, medication, insulin

◯ Y ◯ N

Arthritis (if yes, osteoarthritis, rheumatoid, or psoriatic?)

◯ Y ◯ N

Blistering sunburns (how many and where on body?)

◯ Y ◯ N

High cholesterol

◯ Y ◯ N

Thyroid problem (what type?)

◯ Y ◯ N

Tuberculosis

◯ Y ◯ N

High blood pressure

◯ Y ◯ N

Osteoporosis

◯ Y ◯ N

Blood clots in legs (DVT)

◯ Y ◯ N

Stroke

◯ Y ◯ N

Organ transplant (what type?)

◯ Y ◯ N

Anemia

◯ Y ◯ N

Heart attack

◯ Y ◯ N

Fibromyalgia

◯ Y ◯ N

Blood transfusion (when)

◯ Y ◯ N

Angina/ Coronary artery disease

◯ Y ◯ N

Reflux/ GERD/ Heartburn or peptic ulcers

◯ Y ◯ N

Bleeding disorder

◯ Y ◯ N

Congestive heart failure

◯ Y ◯ N

Emphysema or COPD

◯ Y ◯ N

Anxiety

◯ Y ◯ N

Heart murmur or heart valve problem

◯ Y ◯ N

Melanoma

◯ Y ◯ N

Depression

◯ Y ◯ N

Have you been told to take antibiotics before dental procedures due to a heart murmur, heart valve, or artificial joint?

◯ Y ◯ N

Basal cell or squamous cell skin cancer (where on body, when treated?)

◯ Y ◯ N

Cancer (what type, how treated, and when?)

◯ Y ◯ N

SURGERIES

Abnormal moles proven on biopsy

◯ Y ◯ N

Artificial joint (If yes, which one & when?)

◯ Y ◯ N

Gallbladder removed

◯ Y ◯ N

Heart valve replacement

◯ Y ◯ N

Appendix removed

◯ Y ◯ N

Heart bypass surgery

◯ Y ◯ N

FEMALE PATIENTS

Are you pregnant or breastfeeding?

◯ Y ◯ N

Are you planning to get pregnant? If yes, when:

◯ Y ◯ N

Prone to yeast infections with antibiotics

◯ Y ◯ N

If not, method of birth control: _____

Hysterectomy (if yes, uterus only or uterus and ovaries?)

◯ Y ◯ N

Tubal ligation (tubes tied)

◯ Y ◯ N

Other Medical Problems or Surgeries:

Allergies to medications and type of allergic reaction (example: hives, difficulty breathing, swelling)

Medications (Prescription, Non-Prescription, Vitamins, Herbs):

SKIN TYPE

Skin Type: If 1st exposed to the sun in the summer without sunscreen, would you:

◯ 1. always burn, never tan
◯ 2. always burn, sometimes tan
◯ 3. sometimes burn, always tan gradually
◯ 4. burn minimally, always tan well
◯ 5. rarely burn, tan profusely
◯ 6. never burn, deeply pigmented

SOCIAL HISTORY

Do you smoke or use tobacco?

◯ Y ◯ N

Do you drink alcohol?

◯ Y ◯ N

Number per day: _____ **Number per week:** _____

Number per year: _____ **Marital status:** _____

Children: _____ **Hobbies:** _____

Occupation/ School: _____

FAMILY HISTORY: CIRCLE ANY CONDITIONS AFFECTING A BLOOD RELATIVE. SPECIFY WHO IS AFFECTED BELOW

THE CIRCLE.

Family history conditions

- [ ] Melanoma
- [ ] Basal cell or squamous cell skin cancer
- [ ] Breast Cancer
- [ ] Psoriasis
- [ ] Eczema
- [ ] Hayfever or allergies
- [ ] Asthma
- [ ] Acne

I WOULD LIKE MORE INFORMATION ABOUT (CIRCLE):

I would like more information about

- [ ] Fillers such as Restylane, Radiesse, Juvederm, Lyft, Silk, Voluma, Sculptra, to treat winkles or volumize areas
- [ ] Dark circles or deep tear troughs, sunken eyes
- [ ] Microdermabrasion
- [ ] Chemical peels, Facials
- [ ] Tattoo Removal
- [ ] Laser hair removal
- [ ] Skin care/ Anti-aging products
- [ ] Botox/ Dysport (to treat wrinkles between the eyebrows, around the eyes, forehead, neck)
- [ ] Facial spider veins, broken blood vessels, or redness of the face
- [ ] Spider veins on the legs
- [ ] Brown spots (liver spots) or discoloration on the face, hands, chest, arms
- [ ] Kybella—improves the double chin
- [ ] Cosmetic Mole or skin tag removal

Signature of person filling out this form

Today's date: _____ dd / mm / yyyy **Updated:** _____