WEST SOUND DERMATOLOGY

PATIENT HISTORY AND INTAKE FORM

Date: _____________ Full Name: ____ Date of Birth: ______________

Past Medical History: (please circle all that apply)

Arthritis
Asthma
Atrial fibrillation
Breast Cancer
Coronary Artery Disease
(Heart Disease)
Diabetes

End Stage Renal Disease
(Kidney Disease)
Hepatitis (A / B / C)
High Blood pressure
HIV/AIDS
High Cholesterol

Hypothyroid or Hyperthyroid
Leukemia
Lymphoma
Radiation Treatment
Seizures
Stroke
NONE

Other (circle all that apply or list below):
Autoimmune Disorders Bleeding Disorders Cold Sores on Lips Keloid Formation Scleroderma

____

Past Surgical History:
____
____

Skin Disease History: (please circle all that apply)

Basal Cell Skin Cancer
Blistering Sunburns
NONE

Melanoma
Precancerous Moles

Squamous Cell Skin Cancer
Actinic Keratosis

Do you wear Sunscreen? Yes No
Do you tan in a tanning salon? Yes No Previous
Do you have a family history of skin cancer (basal cell, squamous cell, melanoma)? Yes No
If yes, which relative(s)? ____

Medications: *(Please enter all medications, including dose and frequency* or attach list)
____
____
____
____

Allergies: (Please enter all allergies)
____

Height: __________ **Weight:** __________

Social History: (Please circle all that apply)

Cigarette Smoking: now previously never Alcohol Use: none # of drinks a day: _____________

For patients 65 and older: Have you received a pneumonia vaccination? Yes No

<u>Please complete back side of this form</u> →

Family History of any Medical Conditions (Only first degree relatives; parents and siblings):
____
____

Preferred Language: ________________________Race:_______________________ Ethnic Group:_____________________
(Requirements of the Healthcare Reform Law)

Preferred Pharmacy: _________________________________ Phone#: ________________ City or Zip code:___________

Primary Care Physician: __________________________________ Referring Physician: _____________________________

Review of Systems: Are you currently experiencing any of the following? (Please check yes or no for the following)

Symptom	Yes	No	Symptom	Yes	No
Weight loss			**Shortness of breath**		
Depression			**Chest pain**		
Muscle aches			**Easy bruising**		
Joint pain			**Blood clots**		
Fever			Swollen lymph nodes		

Other Symptoms:
____
____

ALERTS: (please circle all that apply)
Allergy to Adhesive or latex
Allergy to local anesthetics
Allergy to topical antibiotics
Artificial heart valve
Artificial joint replacement
Blood thinners
Defibrillator
MRSA
Pacemaker
Require antibiotics prior to a dental or surgical procedure
Rapid heartbeat with epinephrine
Are you pregnant or currently trying to get pregnant?
Are you currently breastfeeding?

For Internal Use Only
PA FSE INCIDENT TO: YES / NO D/C TO PCP
YES / NO 3 6 12 MD PROVIDER: ______________