WEST SOUND DERMATOLOGY

SIMONE INCE, MD • DIANNE LEVISOHN, MD
HEIDI TATE, PA-C • SARAH SINGLETON, ARNP • ALISON MACKAY, PA-C

History and Intake Form

Name: _____ **Date of Birth:** _____

Past Medical History: (please circle all that apply)

Anxiety	Coronary Artery Disease	Thyroid problems: hyper / hypo
Arthritis	Depression	Leukemia
Asthma	Diabetes	Lung cancer
Atrial fibrillation	End Stage Renal Disease	Lymphoma
Bone Marrow Transplantation	GERD	Prostate Cancer
Breast Cancer	Hearing Loss	Radiation Treatment
Colon Cancer	Hepatitis	Seizures
COPD	High Blood Pressure	Stroke
	HIV/AIDS	
	High Cholesterol	

Other: _____

Past Surgical History: (please circle all that apply)

Appendix Removed	Joint Replacement within last 2 years
Bladder Removed	Kidney Biopsy
Mastectomy (Right, Left, Bilateral)	Kidney Removed (Right, Left)
Lumpectomy (Right, Left, Bilateral)	Kidney Stone Removal
Breast biopsy (Right, Left, Bilateral)	Kidney Transplant
Breast Reduction	Ovaries Removed: Endometriosis
Breast Implants	Ovaries Removed: Cyst
Colectomy: Colon Cancer Resection	Ovaries Removed: Ovarian Cancer
Colectomy: Diverticulitis	Prostate Removed: Prostate Cancer
Colectomy: IBD	Prostate Biopsy
Gallbladder Removed	TURP (Prostate Removal)
Coronary Artery Bypass	Spleen Removed
Mechanical Valve Replacement	Testicles removed (Right, Left, Bilateral)
Biological Valve Replacement	Hysterectomy: Fibroids
Heart Transplant	Hysterectomy: Uterine Cancer
Joint Replacement, Knee (Right, Left, Bilateral)	
Joint Replacement, Hip (Right, Left, Bilateral)	

Other: _____

19917 7TH AVE NE, SUITE 203
POULSBO, WA 98370
(360) 824-5474
(360) 994-4975 FAX
WWW.WESTSOUNDDERM.COM

WEST SOUND DERMATOLOGY

SIMONE INCE, MD • DIANNE LEVISOHN, MD
HEIDI TATE, PA-C • SARAH SINGLETON, ARNP • ALISON MACKAY, PA-C

Skin Disease History: (please circle all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratosis	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/ Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	NONE

Other: _____

Do you wear Sunscreen? ____ Yes ____ No
If yes, what SPF? _____
Do you tan in a tanning salon? ____ Yes ____ No _____ In Past

Do you have a family history of Melanoma? ____ Yes ____ No
If yes, which realtive(s)? _____

Medications: (Please enter all current medications, vitamins, and herbs)
_____
_____
_____
_____

Allergies: (Please enter all allergies and reaction type ie. Rash, swelling etc)
_____
_____

Previous Allergy Testing: ____ No ____ Yes ___ Results:_____

Social History:

Smoking/ Tobacco Use: ☐ Current ☐ Past ☐ Never

Type: _____ Amount/day: _____ Number of Years: _____

Alcohol: ☐ Current ☐ Past ☐ Never Drinks/week: _____

Recreational Drug Use: ☐ Current ☐ Past ☐ Never Type: _____

19917 7TH AVE NE, SUITE 203
POULSBO, WA 98370
(360) 824-5474
(360) 994-4975 FAX
WWW.WESTSOUNDDERM.COM

WEST SOUND DERMATOLOGY

SIMONE INCE, MD • DIANNE LEVISOHN, MD
HEIDI TATE, PA-C • SARAH SINGLETON, ARNP • ALISON MACKAY, PA-C

NON- skin related **Family History**: (Only list first-degree relatives, example: mom, dad, siblings) Please list relative and what type of medical issue they currently have or have had in the past.

Example: Dad, Diabetes. Mom, Lung Cancer

Who:	**Medical Issue:**
_____	_____
_____	_____
_____	_____
_____	_____

Preferred Language (circle one if preferred): English • Spanish • Other: _____

Ethnicity* (circle one): Hispanic or Latino • Not Hispanic or Latino • Unknown • Decline to Specify

Race* (circle one): American Indian/Alaska Native • Asian • Black/African American • White
Native Hawaiian/Other Pacific Islander • Other • Decline to Specify

*Please note that this information is requested per government regulations. If you rather not provide the information, please circle "Decline to Specify".

Preferred Pharmacy Name: _____

Phone #: _____

City or Zip code: _____

Place of Birth: _____ Occupation: _____

Primary Care Provider: _____

Emergency Contact : _____ Phone Number: _____

19917 7TH AVE NE, SUITE 203
POULSBO, WA 98370
(360) 824-5474
(360) 994-4975 FAX
WWW.WESTSOUNDDERM.COM

WEST SOUND DERMATOLOGY
SIMONE INCE, MD • DIANNE LEVISOHN, MD
HEIDI TATE, PA-C • SARAH SINGLETON, ARNP • ALISON MACKAY, PA-C

Review of Systems: Are you currently experiencing any of the following?

Symptom	Yes	No
Problems with bleeding		
Problems with healing		
Problems with scarring (hypertrophic or keloid)		
Rash		
Immunosuppresion		
Hay fever		
Fatigue		
Fever or chills		
Night sweats		
Unintentional weight loss		
Blurry vision		
Abdominal pain		
Joint aches		
Headaches		
Shortness of breath		
Anxiety		
Depression		

Other Symptoms: _____

Alerts: (Please circle all that apply)

Allergy to Adhesive
Allergy to Lidocaine
Allergy to topical antibiotics
Artificial heart valve
Artificial joint replacement
Blood thinners
Defribrillator
MRSA aka Resistant Staph Infection
Pacemaker
Requires antibiotics prior to a surgical procedure
Rapid heartbeat with epinephrine
Pregnant or currently trying to get pregnant

19917 7TH AVE NE, SUITE 203
POULSBO, WA 98370
(360) 824-5474
(360) 994-4975 FAX
WWW.WESTSOUNDDERM.COM