ELITE DERMATOLOGY

PATIENT INTAKE AND HISTORY FORM

Name	Today's Date	Date of Birth

Reason for Visit:

PAST MEDICAL HISTORY

Select any of the following medical conditions you currently have:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone-Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ NONE
- ☐ Other _____
  _____

PAST SURGICAL HISTORY

Have you had any surgeries on the following organs?

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast _____
- ☐ Colon _____
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart _____
- ☐ Joint Replacement _____
- ☐ Kidney _____
- ☐ Liver _____
- ☐ Ovaries _____
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate _____
- ☐ Rectum _____
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Spleen (Splenectomy)
- ☐ Testicles (Orchiectomy)
- ☐ Uterus (Hysterectomy)
- ☐ NONE
- ☐ Other _____

SKIN DISEASE HISTORY

Have you had any of the following?

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

Do you wear Sunscreen? ○ Yes ○ No
If yes, what SPF? _____

Do you tan in a tanning salon? ○ Yes ○ No

Do you have a family history of Melanoma?

○ Yes ○ No

If yes, which relative? _____

MEDICATIONS AND ALLERGIES

List all current medications:

_____
_____
_____
_____

List all allergies and reactions if known:

_____
_____
_____
_____
_____

SKIN CANCER FAMILY HISTORY

ELITE DERMATOLOGY

PATIENT INTAKE AND HISTORY FORM

Mother:
Father:
Sister:
Brother:
Children:

SOCIAL HISTORY

Smoking Status (please choose one):

- ☐ Current every day smoker
- ☐ Current some day 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: _____

Alcohol Intake (please choose one):

- ☐ None
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day

What is your caffeine use?

- ☐ Unspecified
- ☐ Several times a day
- ☐ Once a day
- ☐ A few times a week
- ☐ A few times a month
- ☐ Never
- ☐ Other _____

How often do you exercise?

- ☐ Unspecified
- ☐ Several times a day
- ☐ Once a day
- ☐ A few times a week
- ☐ A few times a month
- ☐ Never
- ☐ Other _____

Driving Status

- ☐ Drive in the Daytime
- ☐ Drive at Night

Occupation/Workplace:

Place of Residence:

REVIEW OF SYSTEMS

Please check yes or no for the following:

Yes	No		Yes	No		Yes	No	
☐	☐	Fever or chills	☐	☐	Immunosuppression	☐	☐	Muscle weakness
☐	☐	Night sweats	☐	☐	Hay fever	☐	☐	Neck stiffness
☐	☐	Unintentional weight loss	☐	☐	Chest pain	☐	☐	Headaches
☐	☐	Problems with bleeding	☐	☐	Thyroid problems	☐	☐	Seizures
☐	☐	Problems with healing	☐	☐	Sore throat	☐	☐	Cough
☐	☐	Problems with scarring	☐	☐	Blurry vision	☐	☐	Shortness of breath
☐	☐	Rash	☐	☐	Abdominal pain	☐	☐	Wheezing
☐	☐	Changes in Moles	☐	☐	Bloody stool	☐	☐	Anxiety
☐	☐	Itching of skin	☐	☐	Bloody urine	☐	☐	Depression
☐	☐	Dryness of skin	☐	☐	Joint aches			

ALERTS

Please check yes or no for the following:

Yes	No		Yes	No	
☐	☐	Hepatitis C Positive	☐	☐	Artificial joints within past two years
☐	☐	HIV positive	☐	☐	Blood thinners
☐	☐	Allergy to adhesive	☐	☐	Defibrillator
☐	☐	Allergy to lidocaine	☐	☐	MRSA
☐	☐	Allergy to topical antibiotic ointments	☐	☐	Pacemaker
☐	☐	Artificial heart valve	☐	☐	Rapid heartbeat with epinephrine
			☐	☐	Pregnancy or planning a pregnancy
			☐	☐	Currently Breastfeeding