Hendersonville Dermatology History and Intake Form

Name: ____ Date of Birth: _______________________

Reason for today's visit:____

Primary Care Physician:____

Please provide name of referring medical professional (if any) ____________________________________

Past Medical History: (please circle all that apply)

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
High Blood pressure
HIV/AIDS
High Cholesterol
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke

NONE

Other ____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Breast Biopsy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Mastectomy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Colon: Colostomy
Gallbladder Removed
Biological Valve Replacement
Coronary Artery Bypass
Heart Transplant
Mechanical Valve Replacement
PTCA
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement, Knee (Right, Left, Bilateral)
Kidney Biopsy (Nephrectomy)
Kidney Stone Removal
Kidney Transplant
Kidney Removed (Right, Left)
Hepatectomy
Liver: Liver Transplant
Liver: Shunt
Ovaries Removed: Endometriosis
Ovaries Removed: Ovarian Cancer
Ovaries Removed: Cyst
Ovaries: Tubal Ligation
Pancreas: Pancreatectomy
Prostate Biopsy
Prostate Removed: Prostate Cancer
TURP (Prostate Removal)
Rectum: APR
Rectum: Low Interior Resection
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Uterus (Hysterectomy): Fibroids
Uterus (Hysterectomy): Uterine Cancer
Uterus (Hysterectomy): Cervical Cancer

NONE

Other ____

Skin Disease History: (please circle all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratoses	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____

Do you have a family history of Melanoma? Yes____ No____

If yes, which relative(s)?

____

Medications: (Please enter all current medications, Dosage, and frequency.)

____
____
____
____

or NONE

Allergies: (Please enter all allergies)

____
____
____
____

or NONE KNOWN

Social History: (Please circle all that apply)

Cigarette Smoking:	**Alcohol Use:**
Currently Smokes	EtOH- None
Has smoked in the past	EtOH- less than 1 drink per day
Never smoked	EtOH -1-2 drinks per day
Former Smoker	EtOH -3 or more drinks per day

How Many times in the last year have you had 5 or more drinks in a day for men, or 4 or more for women or any adult older than 65?____

Family History of Pertinent Medical Conditions: (Only first degree relatives)

____
____
____

Preferred Pharmacy Name: ____

Phone Number: ____________________________ **City or Zip code**:_____________________

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

Symptom	Yes	No
Sensitivity to Topical Antibiotic Ointments		
Hay Fever Symptoms		
Bloody Urine		
Problems with healing		
New or Changing Moles		
Sensitive Skin		
Lumps		
Edema or Swelling		
Cough		
Wheezing		
Breathing issues		
Joint Aches		
Muscle Weakness		
Heat or Cold Intolerance		
Excessive Sweating		
Hormonal or Menstrual Issues		
GI Upset		
Abdominal Pain		
Bloody Stool		
Sleep Issues		
Feels generally well, no fever, chills, unintentional weight-loss		
Night Sweats		
Dizziness		
Difficulty Hearing		
Difficulty Walking		
Numbness or Tingling		
Memory Loss		

ALERTS: (please circle all that apply)
Premedication Prior to Dental Procedures
History of MRSA
Rapid Heart Beat with Epinephrine
Artificial Heart Valve
Defibrillator or Pacemaker
Immunosuppression
Sensitivity to Sutures
Sensitivity to Adhesive Tape
Allergy to Latex
Allergy to Hibiclens
Allergy to Lidocaine
Allergy to 5FU and Imiquimod
Pregnancy or planning a pregnancy
Lactating
Problems with Scarring (Hypertrophic or Keloid)
Anticoagulant/Bleeding Problems
Artificial Joints within the past two years
Implantable electrical neurologic device