Ricks Advanced Dermatology

History and Intake Form

Patient Name: _____ DOB: _____

E-mail: _____

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
Renal Disease
GERD
Hepatitis
High Blood pressure
HIV/AIDS
High Cholesterol
Hypothyroidism
Hyperthyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
NONE

Other _____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Crohn's/Ulcerative Colitis
Gallbladder Removed
Coronary Artery Bypass
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy (Nephrectomy)
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP (Prostate Removal)
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
NONE

Other _____

Skin Disease History: (please circle all that apply)

Actinic Keratoses	Dry Skin/Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Squamous Cell 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 (include dosage))
_____
_____
_____

Allergies: (Please enter all allergies **and** the reaction to that allergy (I.E. rash, shortness of breath, hives)
_____
_____
_____

Social History: (Please circle all that apply)

Cigarette Smoking:

Currently Smokes
Never smoked
Former Smoker

Alcohol Use:

EtOH- None
EtOH- less than 1 drink per day
EtOH -1-2 drinks per day
EtOH -3 or more drinks per day

Other_____

Family History (Only first degree relatives (parent, siblings, children). List any and all known diseases or conditions (I.E. cancer, diabetes and heart disease) and relationship of that individual to you)

_____
_____

Race:

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White
- ☐ Other race _____
- ☐ Decline to specify

Ethnic Group:

- ☐ Hispanic
- ☐ Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown
- ☐ Decline to specify

Preferred Language: _____

Primary Care Provider: _____

Preferred pharmacy Name and Location: _____

Phone#: _____ City or Zip code: _____

ALERTS: (please circle all that apply)

Allergy to Adhesive
Allergy to lidocaine
Allergy to topical antibiotics
Artificial heart valve
Artificial joint replacement
Blood thinners
Defibrillator
MRSA
Pacemaker
Require antibiotics prior to a surgical procedure
Rapid heartbeat with epinephrine
Are you pregnant or currently trying to get pregnant?