Patient Intake Form

**Forms must be filled out completely!**

**Past Medical History**: (please circle all that apply)

Anxiety

Arthritis

Asthma Atrial fibrillation Bone Marrow Transplant

Breast Cancer Colon Cancer

COPD

Coronary Artery Disease Depression Diabetes

End Stage Renal Disease GERD Hearing Loss

Hepatitis High Blood Pressure HIV/AIDS

Thyroid Problems

Leukemia

Lung Cancer Lymphoma Prostate Cancer

Radiation Treatment

Seizures

Stroke

None

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Surgical History**: (please circle all that apply)

Appendix Removed Joint Replacement within last 2 years

Bladder Removed Kidney Biopsy (Nephrectomy)

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) 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 Cancer Hay Fever/ Allergies Squamous Cell Cancer

Blistering Sunburns Melanoma

None

Patient Intake Form

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 with strength and how often you take it)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I authorize Marietta Dermatology and the Skin Cancer Center to retrieve my medication history through their prescribing system and then import it into my electronic record**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature

Allergies( Please enter all allergies)

**Social History: (** Please circle all that apply)

**Cigarette Smoking: Alcohol Use:**

Currently Smokes Do not drink alcohol

Has smoked in the past Less than 1 drink per day

Never Smoked 1-2 drinks per day

Former Smoker 3 or more drinks per day

**If you were or are a smoker**: When did you start?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Quit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_How many

Packs/day:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How many Years:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If you drink alcohol: Men**: How many times in the past year have you had 5 or more drinks in one day?\_\_\_\_\_

**Women and anyone over 65 yrs**: How many times in the last year did you have 4 or more drinks in one day?\_\_\_\_\_\_\_

**Family History**: ( only first degree relatives)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Height:\_\_\_\_\_\_\_\_\_\_\_\_ Pharmacy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Weight:\_\_\_\_\_\_\_\_\_\_ Address/Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Best way to contact you:**

\_\_\_\_\_\_Cell phone \_\_\_\_Home Phone\_\_\_\_Work Phone \_\_\_\_\_Email

**Who is your PCP (Primary Care Physician):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Did a physician refer you today? If so, who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patient Intake Form

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

(Please circle yes or no for the following)

Swollen Lymph Nodes Yes No

Feeling Ill or not feeling well in general Yes No

Problems with bleeding Yes No

Problems with healing Yes No

Problems with scarring Yes No

Rash/Other skin Issues Yes No

Immunosuppression Yes No

Fever or chills Yes No

Unintentional weight loss Yes No

Blurry vision/Visual Changes Yes No

Abdominal pain Yes No

Headaches Yes No

Cough Yes No

Shortness of breath Yes No

Wheezing Yes No

Anxiety Yes No

Muscles weakness Yes No

Depression Yes No

Hay fever Yes No

Joint aches Yes No

Chest Pain Yes No

Sore throat Yes No

Night sweats Yes No

Neck stiffness Yes No

Thyroid problems Yes No

Diarrhea Yes No

**Alerts: (please circle all that apply)**

Allergy to Adhesive

Allergy to Lidocaine

Allergy to topical antibiotics

Allergy to Latex

Allergy to Iodine

Artificial joint replacement

Artificial heart valve

Require antibiotics prior to surgical procedure

Allergy to oral antibiotics

Blood thinners

History of fever blisters

HIV/AIDS

Hepatitis B

Hepatitis C

MRSA

Rapid heartbeat with epinephrine

Neurostimulator/implantable device

Seizures

Kidney disease

C-Diff

Pregnant or currently trying to get pregnant

Other drug Allergies

Pacemaker

Defibrillator