Dermatology
Specialists of Pasadena

History & Intake Form

Full Name: _____
Reason for Visit:_____

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
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
High Blood pressure
HIV/AIDS
High Cholesterol
Thyroid Problems
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke

NONE

Other:_____

Past Surgical History: (please circle all that apply)

Mastectomy (Right, Left, Bilateral)
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
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)
Other_____
Joint Replacement within last 2 years
Kidney Removed (Right, Left)
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Spleen Removed
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer

NONE

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)
_____
_____
_____

Allergies: (Please enter all allergies)
_____
_____
_____

Social History: (Please circle all that apply)

Cigarette Smoking:

Currently Smokes
Has smoked in the past
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 Medical History (Only first degree relatives)

_____
_____
_____
_____

Have you had a Pneumonia Vaccine: Yes / No Date:_____
Have you had a Flu Vaccine: Yes / No Date:_____

Preferred pharmacy: _____

Address: _____
Phone#: _____
City or Zip code: _____

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

Symptom	Yes	No
problems with bleeding		
problems with healing		
problems with scarring		
rash		
sun sensitivity		
immunosuppression		
hay fever		
fevers or chills		
night sweats		
unintentional weight loss		
thyroid problems		
abdominal pain/diarrhea		
joint aches		
muscle weakness		
muscle aches		
headaches		
cough/shortness of breath		
wheezing		
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 or Blood Clots
Defibrillator
MRSA
Pacemaker
Require antibiotics prior to surgical procedures
Rapid heart beat with epinephrine
Are you pregnant or currently trying?