Today's Date: _____ **Name:** _____ **Birth Date:** _____

Referred by: ( ) Dr. _____ City _____ Phone _____

Advanced Dermatology History and Intake Form

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
Kidney Disease
GERD
Hearing Loss
Hepatitis
High Blood pressure
HIV/AIDS
High Cholesterol
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Hypothyroidism
Hyperthyroidism

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: Diverticulitis
Colectomy: Irritable Bowel Disease
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 ( ) Rt, ( ) Lt ( ) BiL
Tonsils & Adenoids removed
Tubal Ligation
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer

NONE

Other _____

Skin Disease History: (*please **check** all that apply*)

( ) Acne	( ) Actinic Keratoses	( ) Basal Cell Skin Cancer
( ) Asthma	( ) Blistering Sunburns	( ) Hay Fever/Allergies
( ) Dry Skin	( ) Flaking or Itchy Scalp	( ) Squamous Cell Skin Cancer
( ) Eczema	( ) Precancerous Moles (dysplastic)	
( ) Poison Ivy	( ) Melanoma	
( ) Psoriasis	( ) Other _____	

Do you wear **Sunscreen**? ( ) Yes ( ) No If yes, what SPF? _____

Do you tan in a **tanning** salon or with a lamp at home? ( ) Yes ( ) No

Do you have a **family history of Melanoma**? ( ) Yes ( ) No

If yes, which relative(s)? _____

Medications: (*Please enter <u>all</u> current medications*)

_____

_____

_____

Allergies: (*Please enter <u>all</u> known allergies*)

_____

_____

_____

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

Cigarette Smoking:
( ) Currently smokes every day
( ) Currently smokes some days
( ) Former Smoker
( ) Never smoked

Alcohol Use:
( ) None
( ) Less than one drink per day
( ) 1 – 2 drinks per day
( ) 3 or more drinks per day

Occupation or Type of Workplace: _____

Residence: ( ) Private Home, ( ) Apartment, ( ) Dormitory, ( ) Nursing Home

Preferred Language: ( ) English Other: _____

Race: _____ **Ethnic Group:**_____

<u>Preferred pharmacy</u>:

_____ Phone#: (___) _____ - _____

City: _____ Zip code: _____

Please **ALERT** us to any of the following that may apply to you:: (***Please check for yes***)

( ) Any allergy to Adhesive
( ) Any allergy to Topical Antibiotics
( ) I have an Artificial Joint Replacement
( ) Do you have a Defibrillator
( ) Do you have a Pacemaker
( ) Require antibiotics prior to surgical procedure
( ) Any allergy to Lidocaine
( ) Do you have an Artificial Heart Valve
( ) Are you taking any Blood Thinners
( ) Have you ever had MRSA
( ) Rapid Heart Beat with Epinephrine

Pregnancy
( ) Are you pregnant or currently trying to be pregnant?
( ) Are you currently breast feeding?

Review of Systems:

Are you currently experiencing any of the following?

( ) Problems with bleeding
( ) Problems with scarring (hypertrophic or keloid)
( ) Immunosuppression (depressed immune system)
( ) Night sweats
( ) Thyroid problems
( ) Blurry vision
( ) Bloody stool
( ) Joint aches
( ) Neck stiffness
( ) Seizures
( ) Shortness of breath
( ) Anxiety
( ) Problems with healing
( ) Rashes
( ) Hay fever
( ) Chest pain
( ) Fever or chills
( ) Unintentional weight loss
( ) Sore throat
( ) Abdominal pain
( ) Bloody urine
( ) Muscle weakness
( ) Headaches
( ) Cough
( ) Wheezing
( ) Depression

Communication Consent

In addition to my consent for treatment, I, and/or for, _____,
Patient's Name

(_____) **Give Permission** or (_____) **Do Not Give Permission**
Initial initial

for representatives of Advanced Dermatology, Inc. and Dr. Monique S. Cohn to communicate information regarding biopsy results and other personal medical and health information regarding diagnoses, treatments and procedures related to my visits at Advanced Dermatology by phone or emails I have provided to the practice. Also, the practice may leave voice messages at my contact numbers and or messages with immediate family members regarding my medical conditions or results.

Signature _____ **Date** ___ / ____ / ____

Patient's name if signing for minor or dependent: _____