Dermatology Practice of the Carolinas
History and Intake Form

Patient: _____ **DOB:** _____ **Today's Date:** _____

Reason for today's visit: _____

Past Medical History: (please circle all that apply)

Anxiety	Depression	Leukemia
Arthritis	Diabetes	Lung Cancer
Artificial joints	End Stage Renal Disease	Lymphoma
Asthma	GERD	Pacemaker
Atrial fibrillation	Hearing Loss	Prostate Cancer
BPH	Hepatitis	Radiation Treatment
Bone Marrow Transplantation	Hypertension	Seizures
Breast Cancer	HIV/AIDS	Stroke
Colon Cancer	Hypercholesterolemia	Valve Replacement
COPD	Hyperthyroidism	None
Coronary Artery Disease	Hypothyroidism	

Other _____

Past Surgical History: (please circle all that apply)

Appendix Removed	Kidney Biopsy
Bladder Removed	Kidney Removed (Right, Left)
Mastectomy (Right, Left, Bilateral)	Kidney Stone Removal
Lumpectomy (Right, Left, Bilateral)	Kidney Transplant
Breast Biopsy (Right, Left, Bilateral)	Ovaries Removed: Endometriosis
Breast Reduction	Ovaries Removed: Cyst
Breast Implants	Ovaries Removed: Ovarian Cancer
Colectomy: Colon Cancer Resection	Prostate Removed: Prostate Cancer
Colectomy: Diverticulitis	Prostate Biopsy
Colectomy: IBD	TURP
Gallbladder Removed	Skin Biopsy
Coronary Artery Bypass	Basal Cell Cancer Surgery
PTCA	Squamous Cell Carcinoma Surgery
Mechanical Valve Replacement	Melanoma Surgery
Biological Valve Replacement	Spleen Removed
Heart Transplant	Testicles Removed (Right, Left, Bilateral)
Joint Replacement, Knee (Right, Left, Bilateral)	Hysterectomy: Fibroids
Joint Replacement, Hip (Right, Left, Bilateral)	Hysterectomy: Uterine Cancer
Joint Replacement within last 2 years	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)
_____
_____

Allergies: (Please enter all allergies and associated reactions)
_____
_____

Social History: (Please circle all that apply)

Currently Smokes - daily	Alcohol - < 1 drink daily	Drug Use
Currently Smokes - not daily	Alcohol - 1-2 drinks daily	None
Has smoked in the past	Alcohol - ≥ 3 drinks daily	Other _____
Has never smoked	Alcohol - none	

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

Symptom	Yes	No
history of melanoma		
pacemaker		
defibrillator		
artificial joints within past two years		
artificial heart valve		
premedication prior to procedures		
allergy to adhesive		
allergy to topical antibiotic ointments		
blood thinners		
pregnancy or planning a pregnancy		
breastfeeding or lactation		
allergy to lidocaine		
rapid heart beat with epinephrine		
problems with bleeding		
problems with healing		
problems with scarring (hypertrophic or keloid)		
yeast infections with antibiotics		
GI upset with antibiotics		
fainting		
immunosuppression		
changing mole		
rash		
hay fever		
wheezing		

Other Symptoms:
_____
_____
_____