DERMATOLOGY ASSOCIATES OF SEATTLE

History and Intake Form

Patient Name: _____ **Date of Birth**_____
Today's date: _____

Past Medical History: (please circle all that apply) ☐ **NONE**

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 A, B or C
High Blood pressure
HIV/AIDS
High Cholesterol
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke

Other _____

Past Surgical History: (please circle all that apply) ☐ **NONE**

Appendix Removed
Lumpectomy (Right, Left, Bilateral)
Mastectomy (Right, Left, Bilateral)
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Biological Valve Replacement
Coronary Artery Bypass
Heart Transplant
Mechanical Valve Replacement
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement, Knee (Right, Left, Bilateral)
Kidney Stone Removal
Kidney Transplant
Kidney Removed (Right, Left)
Liver Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Ovarian Cancer
Ovaries Removed: Cyst
Ovaries: Tubal Ligation
Prostate Removed: Prostate Cancer
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer

Other _____

Skin Disease History: (please circle all that apply) ☐ **NONE**

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
History of cold sores/oral herpes
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer

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)? _____

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Medications: (Please enter all current medications)

Allergies: (Please enter all allergies) ☐ Check here if you have no known drug allergies

Drug allergy:	**Drug reaction:**

Social History: (Please circle all that apply)

Cigarette Smoking:
☐ Currently Smokes
☐ Never smoked
☐ Former Smoker

Alcohol Use:
☐ -None
☐ -Less than 1 drink per da
☐ -1-2 drinks per day
☐ -3 or more drinks per day

Other:
☐ Not sexually active
☐ Sexually active with one partner
☐ Sexually active with more than one partner
☐ Same-sex partner (same gender: female/female or male/male)
☐ Drug use
☐ IV drug use

Occupation: _____

Family Medical History:

Do any of your first degree relatives have any of the following conditions?

Please circle disease and write which first degree relative next to disease

Asthma
Environmental Allergies
Migraines
Skin Cancer (non-melanoma)
Heart Disease
Diabetes
Stroke
Vitiligo
Eczema
Psoriasis

ALERTS: (please circle or check all that apply)

Are you pregnant or currently trying to get pregnant? ☐ Yes ☐ No
Are you currently breastfeeding? ☐ Yes ☐ No
Require antibiotics prior to a surgical procedure ☐ Yes ☐ No

Allergy to Adhesive
Allergy to Lidocaine
Allergy to Topical antibiotics
Artificial heart valve
Artificial joint replacement-
(-within 2 years)
Allergy to latex
Blood thinners
Defibrillator
HIV/AIDS
Pacemaker
Rapid heartbeat with epinephrine
MRSA

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Review of Systems: Are you currently experiencing any of the following?
(Check off for yes, leave blank for no)

Allergic/Immunologic:
o Asthma

Constitutional:
o Excessive fatigue
o Fever or chills

Endocrine:
o Unintentional weight loss

Eyes:
o Visual changes

Gastrointestinal:
o Abdominal pain
o GI upset

Hematology / Oncology/Lymphatic:
o Swollen lymph nodes
o Swelling of hands or feet

Musculoskeletal:
o Back pain
o Joint aches

Neurological:
o Headache

Psychology:
o Anxiety

Preferred Language: _____Race: _____Ethnic Group: _____

Preferred pharmacy Name: _____

Phone#: _____ City or Zip code: _____

Primary Care Doctor: _____
first name last name phone # Clinic name

Referring Doctor (if applicable): _____
first name last name phone # Clinic name