HEARTLAND DERMATOLOGY and SKIN CANCER CENTER, PA

Intake and History Form

Name: _____ Date: _____

Street Address: _____ City/State: _____

Zip Code: _____ Date of Birth: _____ Age: _____ Gender: _____

SSN#: _____ Email Address: _____

Phone Number (home): _____ Phone Number (cell): _____

Phone Number (work): _____ Preferred Contact: Phone / Text / Email

Preferred Language: _____ Race: _____ Ethnic Group: _____

Emergency Contact Name and Phone Number: _____

Place of Birth (City, State and Zip): _____

Employer: _____ Occupation: _____

Primary Care Provider: _____ Referring Provider: _____

Preferred Pharmacy

Name: _____ Phone Number: _____ City: _____

What is the main concern for your visit today? _____

What areas of your body are affected? _____

How long have you had this concern? _____

Symptoms (circle all that apply): pain itch bleeding enlargement spreading burning redness embarrassment blistering other: _____

What oral medications have you tried for this concern? _____

What topical medications (prescription or OTC) have you tried? _____

List any other treatments you have used: _____

Which of these products have been helpful? _____

Past Medical History

Select any of the following medical conditions that you currently have or had have:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ Benign Prostatic Hyperplasia (BPH)
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ Esophageal Reflux (GERD)
- ☐ Hearing Loss
- ☐ Hepatitis (Type): _____
- ☐ Hypertension
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Transplant (Organ): _____
- ☐ Other: _____ _____

Past Surgical History

Select any of the following surgical procedures that you have had:

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast: Breast Biopsy
- ☐ Breast: Lumpectomy (Right / Left / Bilateral)
- ☐ Breast: Mastectomy (Right / Left / Bilateral)
- ☐ Colon (Colectomy): Colon Cancer Resection
- ☐ Colon (Colectomy): Diverticulitis
- ☐ Colon (Colectomy): Inflammatory Bowel Disease
- ☐ Colon: Colostomy
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Coronary Artery Bypass Surgery (CABG)
- ☐ Heart: Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Joint Replacement: Hip (Right / Left / Bilateral)
- ☐ Joint Replacement: Knee (Right / Left / Bilateral)
- ☐ Kidney: Kidney Biopsy
- ☐ Kidney: Kidney Stone Removal
- ☐ Kidney: Kidney Transplant
- ☐ Kidney: Nephrectomy
- ☐ Liver: Hepatectomy
- ☐ Liver: Liver Transplant
- ☐ Liver: Shunt
- ☐ Ovaries (Oophorectomy): Endometriosis
- ☐ Ovaries (Oophorectomy): Ovarian Cancer
- ☐ Ovaries (Oophorectomy): Ovarian Cyst
- ☐ Ovaries: Tubal ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate (Prostatectomy): Prostate Biopsy
- ☐ Prostate (Prostatectomy): Prostate Cancer
- ☐ Prostate (Prostatectomy): TURP
- ☐ Rectum: Abdominal Perineal Resection (APR)
- ☐ Rectum: Lower Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Spleen (Splenectomy)
- ☐ Testicles (Orchiectomy)
- ☐ Uterus (Hysterectomy): Fibroids
- ☐ Uterus (Hysterectomy): Uterine Cancer
- ☐ Uterus (Hysterectomy): Cervical Cancer
- ☐ Other:

_____

_____

_____

Skin Disease History

Have you had any of the following:

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever / Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ 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 malignant melanoma? ◯ **YES** ◯ **NO** **If yes, which relative? _____**

Do you have a family history of Basal Cell Carcinoma (BCC) or Squamous Cell Carcinoma (SCC)? ◯ **YES** ◯ **NO**
If yes, which relative? _____

Medications

List all current medications (prescription, OTC medications and supplements) including dose and frequency:

Medication Name	Dose	Frequency

Allergies

List all allergies to medications

Social History

Smoking Status (Choose one)

- ☐ Current everyday smoker
- ☐ Current occasional smoker
- ☐ Former smoker
- ☐ Never smoker

Alcohol Intake (Choose one)

- ☐ None
- ☐ Less than 1 drink per day
- ☐ 1 to 2 drinks per day
- ☐ 3 or more drinks per day

How many times in the past year have you had 5 (for men) or 4 (for women) or more drinks in a day? _____

For patients 65 and older, have you received the Pneumococcal (Pneumovax) vaccine? ◯ YES ◯ NO

For patients 50 and older, have you received the Shingles (Zostavax) vaccine? ◯ YES ◯ NO

For all patients, have you received the Influenza vaccine this flu season? ◯ YES ◯ NO

Review of Systems

Are you currently or have you recently experienced any of the following (mark all that apply):

- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting
- ☐ Fever or chills
- ☐ Fatigue
- ☐ Night sweats
- ☐ Cough
- ☐ Shortness of breath
- ☐ Unintentional weight loss
- ☐ Weight gain
- ☐ Depression
- ☐ Anxiety
- ☐ Pain/burning on urination
- ☐ New onset of joint aches
- ☐ Numbness/weakness

Alerts

Select any of the following that you have (mark all that apply):

- ☐ Allergy to Adhesive
- ☐ Allergy to Lidocaine
- ☐ Allergy to Topical Antibiotic Ointment
- ☐ Artificial Heart Valve
- ☐ Artificial Joint within the past 2 years
- ☐ Blood Thinners
- ☐ Defibrillator
- ☐ Pacemaker
- ☐ MRSA
- ☐ Premedication Prior to Procedures
- ☐ Rapid Heartbeat with Epinephrine
- ☐ Pregnant
- ☐ Planning Pregnancy
- ☐ Breastfeeding

_____ _____

Patient or Patient Representative Signature Date

_____ _____

Health Care Provider Signature Date