St. Clair Dermatology - Intake and History Form

Name: _____ Date: _____

Street Address: _____ City / State: _____

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

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

Email Address: _____

Emergency Contact: _____

Preferred Language: _____ Race: _____ Ethnic Group: _____

Preferred Pharmacy

Name: _____ Phone: _____ City or Zip Code: _____

Past Medical History – Select any of the following medical conditions you currently have:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ NONE
- ☐ Other:

_____

_____

_____

_____

Past Surgical History – Have you had any surgeries on the following organs?

- ☐ 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
- ☐ 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: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Testicles (Orchiectomy)
- ☐ Uterus (Hysterectomy): Fibroids
- ☐ Uterus (Hysterectomy): Uterine Cancer
- ☐ Uterus (Hysterectomy): Cervical Cancer
- ☐ NONE
- ☐ Other:

_____

_____

Skin Disease History – Have you had any of the following?

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever / Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin cancer
- ☐ 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?

- ☐ Mother
- ☐ Father
- ☐ Sister
- ☐ Brother
- ☐ Daughter
- ☐ Son
- ☐ Uncle
- ☐ Aunt
- ☐ Nephew
- ☐ Niece
- ☐ Grandmother
- ☐ Grandfather
- ☐ Grandson
- ☐ Granddaughter
- ☐ Other:

_____

_____

Current Medications – List all current medications (please include dosing and frequency):

_____ _____

_____ _____

_____ _____

Allergies – List all allergies and reactions if known:

_____ _____

_____ _____

_____ _____

Social History

Smoking Status (please choose one):

- ☐ Current every day smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoker

Start Smoking (mm/dd/yy): _____

Quit Smoking (mm/dd/yy): _____

Number of Packs Per Day: _____

Total Years Smoking: _____

Alcohol Intake (please choose one):

- ☐ None
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day

Driving Status

- ☐ Drives in the Daytime
- ☐ Drives at Night

How often do you exercise?

- ☐ Unspecified
- ☐ Several times a day
- ☐ Once a day
- ☐ A few times a week
- ☐ A few times a month
- ☐ Never
- ☐ Other:

_____

What is your Caffeine Usage?

- ☐ Once a day
- ☐ Several times a day
- ☐ A few times week
- ☐ A few times a month
- ☐ None
- ☐ Other:

_____

Occupation and Workplace:

_____

Family History – Please include only first-degree relatives:

_____

_____

Review of Systems – Please indicate all that apply to you today:

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

- ☐ Allergy to adhesive
- ☐ Allergy to lidocaine
- ☐ Allergy to topical antibiotic ointments
- ☐ Artificial heart valve
- ☐ Artificial joints within past two years
- ☐ Blood thinners
- ☐ Defibrillator
- ☐ MRSA
- ☐ Pacemaker
- ☐ Premedication prior to procedures
- ☐ Rapid heartbeat with epinephrine
- ☐ Pregnancy or planning pregnancy
- ☐ Ebola Risk: Fever >= 100.4 degrees (F) / 38.0degrees (C)
- ☐ Ebola Risk: Resided or traveled to country with widespread Ebola transmission in the last 21 days
- ☐ Ebola Risk: Contact with Ebola patient without proper protective equipment in the last 21 days
- ☐ Ebola Risk: Headaches, weakness, muscle pain, vomiting, diarrhea, abdominal pain, and/or hemorrhage
- ☐ COVID Vaccine

If 66+ years old: Have you received a Pneumonia Vaccine on or after your 60th birthday? ◯ Yes ◯ No

Do you have a healthcare proxy in the event you are unable to make your own medical decisions? ◯ Yes ◯ No

Do you a have a living will? ◯ Yes ◯ No

Which statement(s) best reflects your wishes on advanced care recommendations?

- ☐ Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.
- ☐ Do Not Resuscitate: if my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it is necessary to save my life.
- ☐ Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

Height: _____

Weight: _____