APD Adult & Pediatric Dermatology
Medical Cosmetic

History Intake Form

Patient Name: ____ **Date of Birth:** __________________

Email address: ____

Cell Phone Number:___________________________ **Home Phone Number:**____________________________

Primary Care Physician: ________________________ **Referring Provider:** ______________________________

Preferred Pharmacy Name AND Location (*town/city*): ____

Please check all that apply:

- **Preferred Language:** ____English ____ Other (*Please specify*) __________________________________)
- **Ethnicity:** ____Non Hispanic/Latino _____Hispanic/Latino
- **Race:** ____African American/Black ____American Indian/Alaskan Native ____Asian
  ____Caucasian/White ____Native Hawaiian/Pacific Islander ____Other Race

Skin Disease History: *(Please circle all that apply)*

Acne	Basal Cell Skin Cancer	Eczema	Melanoma	Psoriasis
Actinic Keratoses	Blistering Sunburns	Flaking/Itchy Scalp	Poison Ivy	Squamous Cell Skin Cancer
Asthma	Dry Skin	Hay Fever/Allergies	Precancerous Moles	NONE

Other: ____

Do you wear sunscreen? Yes/No

Do you tan at a tanning salon? Yes/No

Do you have a family history of any of the following skin cancers? Basal Cell Melanoma* Squamous Cell

*If family history of *melanoma*, which relatives? ____

Any other pertinent family history: ____

Past Medical History: *(Please circle all that apply)*

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

Other: ____

PLEASE COMPLETE REVERSE SIDE

Past Surgical History: *(Please circle all that apply)*

Appendix Removed
Bladder Removed
Breast Biopsy
Breast: Lumpectomy (R,L,Bilateral?)
Breast: Mastectomy (R,L,Bilateral?)
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Heart: Biological Valve Replacement
Heart: Coronary Artery Bypass
Heart: Heart Transplant
Heart: Mechanical Valve Replacement
Heart: PTCA
Joint Replacement within last 2 years
Joint Replacement, Hip (R,L,Bilateral?)
Joint Replacement Knee (R,L,Bilateral?)
Kidney Biopsy
Kidney Removed (R,L)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Ovarian Cancer
Ovaries Removed: Ovarian Cyst
Prostate Biopsy
Prostate Removed: Prostate Cancer
Prostate Removed: TURP
Skin: Basal Cell Carcinoma Surgery
Skin: Melanoma Surgery
Skin Biopsy
Skin Squamous Cell Carcinoma Surgery
Spleen Removed
Testicles Removed (R,L,Bilateral)
Uterus (Hysterectomy): Fibroids
Uterus (Hysterectomy): Uterine Cancer
NONE

Other: ____

Medications: (*Please list all current medications [dose/strength and directions] OR provide us with a copy of your medication list*)

____
____
____

Allergies: *(Please list all current medication allergies)*

____
____

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

- Cigarette Smoking: Never Smoked | Quit/Former Smoker | Smokes Less Than Daily | Smokes Daily
- Alcohol Use: Never drinks | <1 drink/day | 1-2 drinks daily | > than 3 drinks daily
- Other: ____

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

Symptom	Yes	No
Currently pregnant or planning a pregnancy		
Excessive scarring		
Immunosuppressed		
Joint pain/swelling		
Problems with bleeding		
Recent fevers		
Recent unintended weight loss		
Other symptoms:		

Alerts: Are you currently experiencing any of the following? *(Please check yes or no for all)*

Alert	Yes	No
Allergy to adhesive		
Allergy to latex		
Allergy to lidocaine/numbing medicine		
Artificial heart valve		
Artificial joints within last 2 years		
Pacemaker/defibrillator		
Other symptoms:		