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ocean state dermatology

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Medical History and Intake Form

Name: _____ DOB: _____

Past Medical History: (please circle all that apply)

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

Other: _____

Past Surgical History: (please circle all that apply)

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

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: _____

Continued on reverse side >

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)? _____
_____

Any other family history: _____

Medications (Please enter all current medications): _____
_____
_____

Allergies (Please enter all allergies): _____
_____
_____

Social History: (Please circle one)

Cigarette Smoking: Never Smoked Quit (former smoker) Smokes less than daily Smokes daily

Alcohol Use: YES NO

Language: English Spanish Other:_____

Race: White African-American Asian Native American/Alaskan Native Hawaiian/Pacific Islander

Ethnicity: Hispanic/Latino Non-Hispanic/Latino

Pharmacy:

Name:_____ Street:_____ Zip:_____

Your Daily Routine:

How often do you exercise? Once a day A few times a week A few times a month Never

What is your caffeine use? Once a day A few times a week A few times a month Never

Your Work:

Occupation: _____

Workplace: _____

Your Residence:

Location: _____

Signature: _____ Date: _____