Medical History and Intake Form

Patient Name: _____ DOB: _____/_____/_____

Primary Care Physician: _____ Referring Physician: _____

☐ As a patient of this practice, I do not permit MD Dermatology to disclose any information regarding my care or treatment to anyone without written permission or legal authorization.

☐ I permit MD Dermatology to disclose any information regarding my care and treatment to:

_____

Pharmacy Name: _____ Pharmacy Phone #: _____

Pharmacy Location (City): _____

Past Medical History (please circle all that apply):

Anxiety
Arthritis
Asthma
Atrial Fibrillation
Bone Marrow Transplant
Enlarged Prostate
Cancer: (type)_____
_____
COPD
Coronary Artery Disease
Depression
Diabetes
End stage Renal (kidney) disease
GERD (acid reflux)
Hearing Loss
Hepatitis/Liver Disease
High Blood Pressure
HIV/AIDS
High Cholesterol
Hyperthyroidism
Hypothyroidism
Radiation Treatment
Seizures
Stroke
None
Other: _____
_____
_____
_____

Past Surgical History:

Appendectomy
Bladder Surgery
Breast Biopsy
Breast Lumpectomy
Mastectomy (indicate Side)
_____
Diverticulitis
Inflammatory Bowel Disease
Colostomy Bag (Colon)
Cholecystectomy (Gallbladder)
Joint Replacement: Hip (left)
Joint Replacement: Hip (right)
Joint Replacement: Knee (left)
Joint Replacement: Knee (right)
Kidney Biopsy
Kidney Stone Removal
Nephrectomy
Hepatectomy
Endometriosis Oophorectomy
Ovarian Cystectomy
Ovarian Cancer Oophorectomy
Valve Replacement of Heart
Pancreatectomy (Pancreas)
Angioplasty
Prostate Biopsy
Prostatectomy
TURP (prostate)
Lower Anterior Resection (Colon)
Melanoma
Splenectomy
Orchiectomy
Fibroidectomy of Uterus
Hysterectomy
Artery Bypass of Heart
Transplant (Indicate which organ)
_____
Other: _____