Island DERMATOLOGY LLC Koru A new and beautiful you
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Island Dermatology LLC DBA Koru Medical Spa

Intake and Health History Form

Patient Information:

First Name:_____Last Name:_____Preferred Name:_____

DOB:_____Gender:_____

Mailing Address:_____City/State:_____Zip:_____

Mobile Phone:_____Home Phone:_____

May we leave voicemails regarding medical details? Circle: Yes or No

Email Address:_____

Primary Care Physician:_____Who referred you?:_____

Month and Year of your last visit with your Primary Care Physician:_____

Preferred Pharmacy (name and city/zip code):_____

For pediatric/minor patients, name/relationship of person completing form:_____

Patient Responsible for Charges:

Is the patient a minor? Circle Yes or No
If yes, what is the patient's relationship to the responsible party?_____

If person responsible for payment is different from patient, then complete section below:

First Name:_____Last Name:_____Contact Number:_____

Mailing Address:_____City/State:_____Zip:_____

Emergency Contact Information:

In Case of an Emergency Notify

Full Name**:**_____Phone:_____

Past Medical History:

*Please circle any of the following medical conditions you currently have OR circle NONE

Anxiety disorder	Elevated blood pressure	Leukemia
Arthritis	End-stage renal disease	Malignant lymphoma (clinical)
Asthma	Epilepsy	Malignant tumor of lung
Atrial fibrillation	Gastroesophageal reflux disease	Malignant tumor of breast
Cerebrovascular accident	Hearing loss	Malignant tumor of colon
Chronic obstructive lung disease	Human immunodeficiency virus infection	Malignant tumor of prostate
Conjunctivitis	Hypercholesterolemia	Radiation therapy
Coronary heart disease	Hyperthyroidism	SARS Corona Virus
Depressive disorder	Hypothyroidism	Transplantation of bone marrow
Diabetes mellitus	Inflammatory disease of liver	Other:_____

Past Surgical History: *Please circle any of the following surgeries you have had or circle NONE

Abdominoperineal resection	H/O: Coronary angioplasty	Prostatectomy
Bilateral replacement of knee joints	H/O: Tissue graft heart valve replacement	Prosthetic arthroplasty of hip(s)
Biopsy of breast	H/O: Total cystectomy	Splenectomy
Biopsy of prostate	H/O: Transurethral prostatectomy	Surgical biopsy of skin
Coronary artery bypass graft	Hysterectomy	Total nephrectomy
Entire transplanted kidney	Kidney biopsy	Total orchidectomy
Excision of basal cell carcinoma	Low anterior resection of rectum	Total replacement of left hip
Excision of melanoma	Lumpectomy of breast- Left/Right	Total replacement of right hip
Excision of squamous cell carcinoma	Mastectomy of left breast	Total replacement of left knee
H/O: Colostomy	Mastectomy of right breast	Total replacement of right knee
H/O: Tubal ligation	Mechanical heart valve replacement	Transplantation of heart
H/O: Appendectomy	Oophorectomy	Transplantation of liver
H/O: Bilateral mastectomy	Pancreatectomy	Other:_____
H/O: Cholecystectomy	Percutaneous extraction of kidney stone	_____
H/O: Colectomy	Portosystemic shunt operation	

Skin Disease History:

*Have you had any of the following?

- o Acne
- o Actinic keratosis
- o Dry, scaly, cracking skin (asteatosis)
- o Basal cell carcinoma of skin
- o Contact dermatitis due to poison ivy
- o Dysplastic nevus of skin
- o Eczema
- o H/O: asthma
- o H/O: hay fever
- o Malignant melanoma
- o Itchy scalp
- o Psoriasis
- o Squamous cell carcinoma
- o Sunburn of second degree
- o None
- o Other:_____

Do you have a family history of Melanoma?
Please circle: YES or NO

If yes, which relative:_____

Do you wear sunscreen?
Please circle: YES or NO

If yes, what SPF:_____

Do you tan in a tanning salon?
Please circle: YES or NO

Medications:
List all current medications or provide a medication list to your provider *(please include frequency and dose):*

_____

_____

_____

Allergies:
List all allergies and reactions if known:

_____

Social History: (please choose one in each category)

Smoking Habits:

- o Never
- o Unknown if I ever smoked
- o Current everyday smoker
- o Current some day smoker (tobacco)
- o Current some day smoker (cigarette)
- o Former smoker
- o Everyday smoker
- o Smoker, current status unknown
- o Cigar smoker
- o Heavy tobacco smoker
- o Light tobacco smoker

Alcohol and Drug Use:

How many times in the past year you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women or any adult older than 65?_____

How often do you consume alcohol (EtOH or grain alcohol)?

- o Less than 1 drink per day
- o 1-2 drinks per day
- o 3 or more drinks per day

Driving Status:

- o Drives in the Daytime
- o Drives at Night

How often do you Exercise?

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

What is your caffeine use?

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

Review of Systems:

Please circle all that apply within the last 6 months or circle NONE

Allergy to adhesive	Problems with bleeding	Abdominal pain
Allergy to lidocaine	Problems with healing	Bloody stool
Allergy to topical antibiotic ointments	Problems with scarring (hypertrophic/keloid)	Bloody urine
Artificial heart valve	Rash	Joint aches
Artificial joint within past two years	Immunosuppression	Muscle weakness
Blood thinners	Hay fever	Neck stiffness
Defibrillator	Chest pain	Headaches
MRSA	Fever or chills	Seizures
Pacemaker	Night sweats	Cough
Premedication prior to procedures	Unintentional weight loss	Shortness of breath
Rapid heart beat with epinephrine	Thyroid problems	Wheezing
Pregnancy or planning a pregnancy	Sore throat	Anxiety
	Blurry vision	Depression

Have you:

Come into contact with anyone confirmed or exhibiting signs of COVID? Yes or No

Had a new loss of taste, smell or red colored toes? Yes or No

Have you traveled in the last 14 days? Yes or No

For Medicare and Medicare Advantage Patients ONLY:

Have you received a pneumonia vaccination? Yes or No

Advance Care (QM47)

Do you have a health care proxy in the event you are unable to make your own medical decisions? Yes or No

Do you have a living will? Yes or 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 its necessary to save my life.
- ○ Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) /

Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Acknowledgement of Receipt of Notice of Privacy Practices and Patient Rights

I, _____, hereby acknowledge that I have read this practice's Notice of Privacy Practices and Patient Rights. I have been given the opportunity to ask any questions I may have regarding these Notices.

_____ _____

Patient's (or Legal Guardian's Signature) Date

_____ _____

Witness's Signature Date

*Note: If you would like a copy of our Notice of Privacy Practices and/or Patient Rights, please let one of our staff members know.