Island
DERMATOLOGY LLC
75-5995 Kuakini Hwy, Suite 443
Kailua Kona, HI 96740
Phone (808) 323-2608 Fax (808) 885-9793

INTAKE AND HEALTH HISTORY FORM

PATIENT INFORMATION:

Last Name: _____ First Name: _____ MI: ____ Preferred Name: _____

Marital Status: _____ Date of Birth: _____ SSN: _____

Birth Sex (circle one): MALE FEMALE Race: _____ Language: _____

Ethnic Group (circle one): HISPANIC/LATINO NOT HISPANIC/LATINO DECLINE TO ANSWER

PATIENT CONTACT INFORMATION:

Patient Home Phone#: _____ Patient Mobile Phone#: _____

Email address: _____ Spouse Full Name: _____ Phone#: _____

Mailing Address: _____ City/State: _____ Zip: _____

Emergency Contact Full Name: _____ Phone#: _____ Relationship to Patient: _____

GUARANTOR/RESPONSIBLE PARTY INFORMATION:

If person responsible for payment is different from the patient, please complete the section below.

Is the patient a minor (circle one)? YES NO Patients relationship to Guarantor: _____

Guarantor's Last Name: _____ Guarantor's First Name: _____

Contact Information same as Patient's (circle one)? YES NO If NO, please complete below:

Mailing Address: _____ City/State: _____ Zip: _____

Home Phone#: _____ Mobile Phone#: _____

INSURANCE INFORMATION:

Primary Insurance Carrier: _____ Subscriber's Name: _____

Subscriber's DOB: _____ Policy#: _____ Group#: _____

Patient's relationship to Subscriber: _____

Secondary Insurance Carrier: _____ Subscriber's Name: _____

Subscriber's DOB: _____ Policy#: _____ Group#: _____

Patient's relationship to Subscriber: _____

PHARMACY

Pharmacy Name: _____ Pharmacy Location: _____

PRIMARY CARE PROVIDER

PCP Name: _____ Office Phone#: _____

If Referred by Provider, please list Provider Name: _____ Office Phone#: _____

PAST MEDICAL CONDITIONS:

Please check the box of any of the following medical conditions you have had or that you currently have or check NONE.

☐ None	☐ Human immunodeficiency virus infection
☐ Anxiety disorder	☐ Hypercholesterolemia
☐ Arthritis	☐ Hyperthyroidism
☐ Asthma	☐ Hypothyroidism
☐ Atrial fibrillation	☐ Inflammatory disease of liver
☐ Cerebrovascular accident	☐ Leukemia
☐ Chronic obstructive lung disease	☐ Malignant lymphoma
☐ Conjunctivitis	☐ Malignant tumor of breast
☐ Coronary arteriosclerosis	☐ Malignant tumor of colon
☐ Depressive disorder	☐ Malignant tumor of lung
☐ Diabetes mellitus	☐ Malignant tumor of prostate
☐ Elevated blood pressure	☐ Radiation therapy treatment management
☐ End-stage renal disease	☐ SARS coronavirus
☐ Epilepsy	☐ Total replacement of left hip joint
☐ Gastroesophageal reflux disease	☐ Total replacement of left knee joint
☐ Generalized anxiety disorder	☐ Total replacement of right hip joint
☐ H/O: hypertension	☐ Total replacement of right knee joint
☐ Hearing Loss	☐ Total shoulder replacement
☐ Human herpes simplex virus type 1	☐ Transplantation of bone marrow
☐ Human herpes simplex virus type 2	☐ Other _____

PAST SURGICAL HISTORY:

Please check the box of any of the following surgeries you have had or check NONE.

☐ None	☐ History of transurethral prostatectomy
☐ Abdominoperineal resection	☐ Hysterectomy
☐ Biopsy of breast	☐ Kidney biopsy
☐ Biopsy of prostate	☐ Low anterior resection of rectum
☐ Coronary artery bypass graft	☐ Lumpectomy of breast
☐ Endoscopic carpal tunnel release	☐ Mastectomy of left breast
☐ Entire transplanted kidney	☐ Mastectomy of right breast
☐ Excision of basal cell carcinoma	☐ Mechanical heart valve replacement
☐ Excision of melanoma	☐ Oophorectomy
☐ Excision of squamous cell carcinoma	☐ Pancreatectomy
☐ H/O: colostomy	☐ Percutaneous extraction of kidney stone with
☐ H/O: tubal ligation	☐ Portosystemic shunt operation
☐ History of appendectomy	☐ Prostatectomy
☐ History of bilateral mastectomy	☐ Splenectomy
☐ History of cholecystectomy	☐ Surgical biopsy of skin
☐ History of colectomy	☐ Total nephrectomy
☐ History of liver excision	☐ Total orchidectomy
☐ History of percutaneous transluminal	☐ Transplantation of heart
☐ History of tissue graft heart valve	☐ Transplantation of liver
☐ History of total cystectomy	☐ Other

SKIN CONDITIONS:

Please check the box of any of the skin conditions you have had or that you currently have or check NONE.

☐ None	☐ H/O: hay fever
☐ Acne	☐ Malignant melanoma
☐ Actinic keratosis	☐ Pruritus of scalp
☐ Basal cell carcinoma of skin	☐ Psoriasis
☐ Contact dermatitis due to poison ivy	☐ Seborrheic dermatitis
☐ Dry skin	☐ Squamous cell carcinoma
☐ Dysplastic nevus of skin	☐ Sunburn of second degree
☐ Eczema	☐ Other _____
☐ H/O: asthma	

SKIN PROTECTION:

Do you wear sunscreen (circle one)? YES NO If YES, what SPF? _____

Do you tan in a tanning salon (circle one)? YES NO

FAMILY HISTORY OF MELANOMA:

Do you have a family history of Melanoma (circle one)? YES NO

☐ None	☐ Aunt
☐ Mother	☐ Nephew
☐ Father	☐ Niece
☐ Sister	☐ Grandmother
☐ Brother	☐ Grandfather
☐ Daughter	☐ Grandson
☐ Son	☐ Granddaughter
☐ Uncle	☐ Other _____

MEDICATIONS:

Please list all current medications or provide a medication list to your provider. Please include frequency and dose.

1. _____
2. _____
3. _____
4. _____
5. _____

ALLERGIES:

Please list all allergies and reactions if known:

1. _____
2. _____
3. _____

SOCIAL HISTORY:

Smoking Habits - What is your smoking status? Please check one of the following:

- ☐ Never smoker
- ☐ Unknown if I ever smoke
- ☐ Current every day smoker
- ☐ Current some day smoker (tobacco)
- ☐ Current some day smoker (cigarette)
- ☐ Former smoker
- ☐ Smoker, current status unknown
- ☐ Cigar smoker
- ☐ Heavy tobacco smoker
- ☐ Light tobacco smoker

Alcohol and Drug Use - How many times in the past year have 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? _____

Do you consume alcohol (EtOH or grain alcohol)? Please check one of the following:

- ☐ None
- ☐ Less than 1 drink per day
- ☐ 1-2 Drinks per day
- ☐ 3 Or more drinks per day

Any illicit drug use?

- ☐ Yes If Yes, please list: _____
- ☐ No

Driving status - Check all that apply:

- ☐ Drives in the Daytime
- ☐ Drives in the Night

Exercise Status - Check the box of the frequency that best applies:

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

Caffeine Usage - Check the box of the frequency that best applies:

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

How did you hear about us (circle one): INSURANCE GOOGLE OUR WEBSITE

PHYSICIAN REFERAL PATIENT REFERRAL OTHER: _____