DOCS
DERMATOLOGY GROUP

MEDICAL HISTORY INTAKE FORM

Patient: _____ Date of Birth: _____
Last First

Do you have any of the following medical conditions? (Please check all that apply)

☐ Anxiety ☐ Arthritis ☐ Asthma ☐ Atrial Fibrillation ☐ Bone Marrow Transplant ☐ BPH ☐ Breast Cancer ☐ Colon Cancer ☐ COPD ☐ Coronary Artery Disease ☐ Depression	☐ Diabetes ☐ Excessive Sweating ☐ GERD ☐ Gallbladder Disease ☐ Hearing Loss ☐ Hepatitis ☐ Hypertension ☐ HIV/ AIDS ☐ Hypercholesterolemia ☐ Hyperthyroidism ☐ Hypothyroidism ☐ Leukemia	☐ Lung Cancer ☐ Lymphoma ☐ Prostate Cancer ☐ Renal Disease ☐ Seizures ☐ Stroke ☐ None ☐ Other _____ ☐ Other _____ ☐ Other _____

Do you have any surgeries/ procedures? (Please check all that apply)

☐ Appendix (Appendectomy) ☐ Bladder (Cystectomy) ☐ Breast: lumpectomy (Right, Left, Bilateral) ☐ Breast: Mastectomy (Right, Left, Bilateral) ☐ Chemotherapy ☐ Colon: Colostomy ☐ Gallbladder (Cholecystectomy) ☐ Heart: Coronary Artery bypass Surgery ☐ Heart: Heart Transplant ☐ Heart: Mechanical Valve ☐ Heart: PTCA	☐ Joint Replacement: Hip (Right, Left, Bilateral) ☐ Joint Replacement: Knee (Right, Left, Bilateral) ☐ Kidney: Dialysis ☐ Kidney: Kidney Transplant ☐ Kidney: Nephrectomy ☐ Liver: Hepatectomy ☐ Liver: Liver Transplant ☐ Pancreas: Pancreatectomy ☐ Prostate (Prostatectomy): TURP	☐ Radiation Treatment ☐ Spleen (Splenectomy) ☐ Testicles (Orchiectomy) ☐ Uterus (Hysterectomy) ☐ None ☐ Other _____ ☐ Other _____ ☐ Other _____ ☐ Other _____

Do you have any of the following skin conditions? (Please check all that apply)

☐ Acne ☐ Actinic Keratoses ☐ Basal Cell Skin Cancer ☐ Blistering Sunburn ☐ Dry Skin ☐ Eczema ☐ Flaking or Itchy Scalp	☐ Hay Fever / Allergies ☐ Melanoma ☐ MRSA ☐ Poison Ivy ☐ Precancerous Moles ☐ Psoriasis ☐ Squamous Cell Skin Cancer ☐ None ☐ Other _____	Do you have a family history Melanoma? ☐ Yes ☐ No If yes, which relative? _____ Smoking Status: ☐ Current ☐ Never ☐ Former Advanced Care Plan (over 65): ☐Yes ☐ No

Do you have any drug allergies? If so, please list below:

_____

Do you take any medications: If so, please list below:

_____

_____

_____

_____

_____

_____

_____

Signature: _____ Date: _____