Dermatology Center of Dallas

NAME:____**DATE OF BIRTH:**________________**DATE:**____________

HISTORY AND INTAKE FORM

- **Past Medical History**: (Please circle all that apply.)

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

Other____

- **Past Surgical History**: (Please circle all that apply.)

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

Other____

- **Skin Disease History**: (Please circle all that apply.)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Bleed easily
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Keloid scars after surgery
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
None

Other____

- **Social History:** (Please circle one.)

Do you wear sunscreen? YES NO

If yes, what SPF? __________

Do you currently tan in a tanning salon? YES NO

Do you have a history of tanning in a tanning salon? YES NO

Do you have a family history of Melanoma? YES NO

If yes, which relative(s)?____

Any family history of other skin cancers?______________________________________

- **Medications:** (Please enter all current medications and dosages.)

____

____

- **Allergies:** (Please enter all allergies.)

____

____

- **Skin Rashes and/or Reactions:** (Please circle.)

Bandages Metal jewelry Polysporin Latex rubber Neosporin

- **Various:** (Please circle one.)

Cigarette Smoking:	Alcohol Use:	Language:
Never smoked	YES	English
Quit: former smoker	NO	Spanish
Smokes less than daily		Other_______________
Smokes daily		

Do you use any recreational drugs?____

What is your occupation?____

(Women) Are you pregnant? YES NO If yes, when is your due date?________/_______/________

Race:
White
Black/African American
Asian
American Indian or Native Alaskan
Native Hawaiian/Pacific Islander

Ethnicity:
Hispanic/Latino
Non-Hispanic/Latino

Which pharmacy do you use?

Name:____

Address:____

Phone Number:_________________________________Fax Number:_____________________________