Midwest Dermatology Clinic, PC

History and Intake Form

Patient Name: _____ Date: _____

In the event that we are unable to reach you directly, can we leave a detailed message on your phone? YES NO

Pharmacy Name: _____

Phone#: _____

City or Zip code:_____

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone Marrow Transplant
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
High Blood pressure
High Cholesterol
Hyper-THYROID
Hypo - THYROID
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke

NONE

Other _____

Past Surgical History: (please circle all that apply)

Joint Replacement, Knee (Right, Left, Bilateral) Year _____

Joint Replacement, Hip (Right, Left, Bilateral) Year _____

Heart Transplant
Kidney Transplant
Hysterectomy

Other _____

Patient Name _____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratosis
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer

NONE

Other _____

Do you wear Sunscreen? Yes No
If yes, what SPF? _____
Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____

Medications: **Please bring a typed medication list or print all current medications**
_____
_____
_____

Allergies to Medications Please list
_____
_____
_____

Social History: (Please circle all that apply)

Cigarette Smoking:

Currently Smokes
Has smoked in the past
Never smoked

Alcohol Use:

None
Less than 1 drink per day
1-2 drinks per day
3 or more drinks per day

Family History(Only first degree relatives)
_____
_____
_____

MIDWEST DERMATOLOGY CLINIC, PC

Patient Name: _____

Review of Systems: Are you currently experiencing any of the following?
(Please check yes or no for each of the following)

Symptom	Yes OR	No
Problems with bleeding		
Problems with healing		
Problems with scarring		
Rash		
Immunosuppression		
Thyroid problems		
Joint Aches		

Other Symptoms: _____

ALERTS: (please circle all that apply)

	Yes	NO
Allergy to Adhesive	☐	☐
Allergy to Latex	☐	☐
Allergy to lidocaine	☐	☐
Allergy to topical antibiotics	☐	☐
Artificial heart valve	☐	☐
Artificial joint replacement	☐	☐
Blood thinners	☐	☐
Defibrillator	☐	☐
Hepatitis	☐	☐
HIV	☐	☐
MRSA	☐	☐
Pacemaker	☐	☐
Require antibiotics prior to a surgical procedure	☐	☐
Rapid heartbeat with epinephrine	☐	☐
TB	☐	☐
Are you pregnant or currently trying to get pregnant?	☐	☐