THE DERMATOLOGY CLINIC
OF ARKANSAS

History and Intake Form

NAME: _____ **DATE OF BIRTH:**____/____/____

Past Medical History: (please **circle** all that apply)

Anxiety
Arthritis
Artificial joints
Asthma
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
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
None
Other _____

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Skin Disease History: (please **circle** all that apply)

Acne
Actinic Keratoses
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 **Do you tan in a tanning salon?** Yes No
If yes, what SPF? _____

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

Medications: (Please enter all **current** medications)

_____
_____
_____
_____
_____
_____
_____

Allergies: (Please enter all **MEDICATION** allergies)

_____
_____
_____
_____
_____
_____
_____

THE DERMATOLOGY CLINIC OF ARKANSAS

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

Cigarette Smoking: (13 and Older)
Never smoked
Quit: former smoker
Smokes less than daily
Smokes daily

Alcohol Use:
YES
NO

Language:
English
Spanish
Other: _____

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

Ethnicity:
Hispanic/Latino
Non-Hispanic/Latino

Driving Status:
Drives in the Daytime
Drives at Night

What is your caffeine use?
Once a day
A few times a week
A few times a month
Never

How often do you exercise?
Once a day
A few times a week
A few times a month
Never

Occupation and Workplace: _____

Residence/Facility: _____

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OF ARKANSAS

REVIEW OF SYSTEMS
Established Patient

Problems with Healing	**Yes**	**No**
Problems with Scarring	**Yes**	**No**
Rash	**Yes**	**No**
Photosensitivity	**Yes**	**No**
Nodules / Other Types of Lesions	**Yes**	**No**
Fever Blisters / Oral Herpes Infections	**Yes**	**No**
Genital Lesions	**Yes**	**No**
History of Shingles	**Yes**	**No**
Problems with Bleeding	**Yes**	**No**
Hay Fever	**Yes**	**No**
Fever or Chills	**Yes**	**No**
Frequent Infections	**Yes**	**No**
Thyroid Problems	**Yes**	**No**
Nausea / Vomiting	**Yes**	**No**
Constipation / Diarrhea	**Yes**	**No**
Joint Aches	**Yes**	**No**
Muscle Weakness	**Yes**	**No**
Arthritis	**Yes**	**No**
Headaches	**Yes**	**No**
Fear of Cancer	**Yes**	**No**
Thrush	**Yes**	**No**
Blood Thinners	**Yes**	**No**
Pacemaker	**Yes**	**No**
Defibrillator	**Yes**	**No**
Artificial Heart Valve Within Last Two Years	**Yes**	**No**
Rapid Heartbeat with Epinephrine	**Yes**	**No**
Allergy to Lidocaine	**Yes**	**No**
Allergy to Adhesive	**Yes**	**No**
Allergy to Latex	**Yes**	**No**
Allergy to Topical Antibiotic Ointment	**Yes**	**No**
Premedications Prior to Procedures	**Yes**	**No**
Pregnancy or Planning a Pregnancy	**Yes**	**No**
MRSA	**Yes**	**No**

_____ _____ / _____ / _____

Patient Name Date of Birth