Hendersonville DERMATOLOGY

Medical History and Intake Form

Name: _____ Date of Birth: _____

Reason for today's visit:_____

Primary Care Physician:_____ Location:_____Phone:_____

Please provide name of referring medical professional (if any):_____

Please provide any other medical providers you might wish to share:_____
_____
_____

Past Medical History: (please circle all that apply)

NONE

Arthritis
Asthma
Atrial fibrillation
Cerebrovascular accident (stroke)
Chronic obstructive lung disease
Coronary arteriosclerosis
Depressive disorder
Diabetes mellitus
Disease caused by covid-19
Elevated blood pressure
End stage renal disease
Epilepsy
GERD
Hypertension
Hearing loss
Hepatitis
HIV/AIDS
High cholesterol
Hyperthyroidism
Hypothyroidism
Leukemia
Malignant lymphoma
Malignant tumor of lung
Malignant tumor of breast
Malignant tumor of colon
Malignant tumor of prostate
Radiation treatment
Transplantation of bone marrow

Other _____

Past Surgical History: (please circle all that apply)

NONE

Bilateral replacement of knee joints
Biopsy of breast
Biopsy of prostate
Coronary artery bypass graft
Entire transplanted kidney
Excision of basal cell carcinoma
Excision of melanoma
Excision of squamous cell carcinoma
History of tubal ligation
History of bilateral mastectomy
History of cholecystectomy
History of colectomy
History of percutaneous transluminal coronary angioplasty
History of tissue graft heart valve replacement
History of transurethral prostatectomy
Hysterectomy
Kidney biopsy
Lumpectomy of breast
Lumpectomy of left breast
Lumpectomy of right breast
Mastectomy of left breast
Mastectomy of right breast
Mechanical heart valve replacement
Oophorectomy
Prostatectomy
Prosthetic arthroplasty of bilateral hips
Splenectomy
Total nephrectomy
Total orchidectomy
Total replacement of left hip joint
Total replacement of left knee joint
Total replacement of right hip joint
Total replacement of right knee joint
Transplantation of heart
Transplantation of liver

Other _____

Skin Disease History: (please circle all that apply)

NONE

Acne	Eczema	Pruritus of scalp
Actinic keratoses	History of asthma	Psoriasis
Basal cell skin cancer	History of hay fever	Squamous cell skin cancer
Dysplastic nevus of skin	Malignant melanoma skin cancer	

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 enter all current medications, Dosage, and frequency.)

_____
_____
_____
_____
_____

or NONE

Allergies: (Please enter all allergies, and reaction)

_____
_____
_____
_____

or NO KNOWN

Social History: (Please circle all that apply)

Alcohol Use:
EtOH- None
EtOH- less than 1 drink per day
EtOH -1-2 drinks per day
EtOH -3 or more drinks per day

Cigarette Smoking:
Currently smokes
Cigar smoker
Former smoker
Never smoked

How many times in the last year have you had 5 or more drinks in a day for men, or 4 or more for women or any adult older than 65? _____

Family History of Pertinent Medical Conditions: (Only first degree relatives)

_____
_____
_____

Preferred Pharmacy Name: _____

Phone Number: _____ Store #:_____

Address:_____ Zip code:_____

Occupation: _____

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

Symptom	Yes	No
Sensitivity to Topical Antibiotic Ointments		
Hay Fever Symptoms		
Bloody Urine		
Problems with Healing		
New or Changing Moles		
Sensitive Skin		
Lumps or Lymph Nodes		
Edema or Swelling		
Cough		
Wheezing		
Breathing Issues		
Joint Aches		
Muscle Weakness		
Heat or Cold Intolerance		
Excessive Sweating		
Hormonal or Menstrual Issues		
GI Upset		
Abdominal Pain		
Bloody Stool		
Sleep Issues		
Feels generally well, no fever, chills, or unintentional weight-loss		
Night Sweats		
Dizziness		
Difficulty Hearing		
Difficulty Walking		
Numbness or Tingling		
Memory Loss		

ALERTS: *(please circle all that apply)*
Premedication prior to procedures
History of MRSA
Rapid heart beat with epinephrine
Artificial heart valve
Defibrillator or pacemaker
Immunosuppression
Allergy to Sutures
Allergy to Adhesive Tape
Allergy to Latex
Allergy to Hibiclens
Allergy to Lidocaine
Allergy to 5FU and Imiquimod
Pregnancy or planning a pregnancy
Lactating
Problems with scarring (Hypertrophic or Keloid)
Anticoagulant/bleeding problems
Artificial joints within the past two years
Implantable electrical neurologic device

Are you up to date on your Flu vaccine? _____
Are you up to date on the Pneumonia vaccination? _____
Have you received the Shingles vaccination? _____
Have you received the Covid vaccination? _____