

## HISTORY & INTAKE FORM

Patient: \_\_\_\_\_ Medical Record #: \_\_\_\_\_

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

Anxiety	Depression	Leukemia
Arthritis	Diabetes	Lung Cancer
Artificial Joints	End Stage Renal Disease	Lymphoma
Asthma	GERD	Pacemaker
Atrial Fibrillation	Hearing Loss	Prostate Cancer
BPH	Hepatitis	Radiation Treatment
Bone Marrow Transplantation	Hypertension	Seizures
Breast Cancer	HIV/AIDS	Stroke
Colon Cancer	Hypercholesterolemia	Valve Replacement
COPD	Hyperthyroidism (overactive)	None
Coronary Artery Disease	Hypothyroidism (underactive)	

Other \_\_\_\_\_

### Past Surgical History: (please circle all that apply)

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

Other \_\_\_\_\_

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

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

Other \_\_\_\_\_

Do you wear sunscreen?    Yes    No  
 Do you have a history of non-melanoma skin cancer?    Yes    No  
 Do you have a family history of Melanoma?    Yes    No  
 If yes, which relative(s)? \_\_\_\_\_

**Cautions:** (please circle all that apply)

Have you ever had difficulty stopping bleeding?    Yes    No  
 Do you require antibiotics prior to a surgical procedure?    Yes    No  
 Have you had an artificial joint replacement?    Yes    No  
   If yes, when and what body locations? \_\_\_\_\_  
 Do you have an artificial heart valve?    Yes    No  
 Do you have a pacemaker?    Yes    No  
 Do you have a defibrillator?    Yes    No  
 Are you pregnant or currently trying to get pregnant?    Yes    No

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

- |          |           |
|----------|-----------|
| 1. _____ | 6. _____  |
| 2. _____ | 7. _____  |
| 3. _____ | 8. _____  |
| 4. _____ | 9. _____  |
| 5. _____ | 10. _____ |

**Allergies:** (please enter all allergies and reactions)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Social History:** (please circle all that apply)

Currently Smoke    Has Smoked in the past    Drug Use    None  
 Other \_\_\_\_\_

Does your insurance require you to use a certain lab?    Yes    No

**Do We Have Your Permission To:**

Leave A Message On Your Answering Machine At Home?    Yes    No  
 Leave A Message At Your Place Of Employment?    Yes    No  
 Discuss Your Medical Condition With Any Member Of Your Household?    Yes    No  
 If Yes, Whom: \_\_\_\_\_ Relationship: \_\_\_\_\_

**All Patients Please Sign**

- I Authorize The Release Of Any Medical Information Needed To Process Medicare And/Or Other Insurance
- I Authorize Dermatology Associates Of Northeast Georgia To Treat The Above Named Patient As Necessary
- I Authorize The Release Of Any Medical Information To Any Physician Or Physician's Office, Laboratory, Pharmacy, Hospital Or Surgical Facility Involved In My Care. I Have Read The Hippa Privacy Policy Of Dermatology Associates Of Northeast Georgia.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Patient / Parent or Guardian