Southwest Skin Specialists, Ltd. Medical Intake Form

Name: _____ **Preferred Language:** _____ **Date of Visit:** _____

Date of Birth: _____ **Place of Birth:**_____ **Ethnic Group:** ☐ Prefer not to specify ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Race: ☐ Prefer not to specify
☐ White ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander
☐ Asian ☐ Black or African American ☐ Other: _____

Primary Care Physician: _____ **Referred by:** _____

Preferred Pharmacy: _____ **Phone:** _____ **City or Zip code:** _____

Please describe your skin problem(s) & reason for today's visit: _____

_____

Area(s) involved: _____ **How long have you had the problem(s):** _____

Please check appropriate box (Y/N) as each applies to your CURRENT OR PAST MEDICAL HISTORY:

*Artificial heart valve / Infection	☐Y ☐N	Diabetes	☐Y ☐N	Hyperthyroid	☐Y ☐N
*Artificial joint (past 2 years)	☐Y ☐N	High blood pressure	☐Y ☐N	Hypothyroid	☐Y ☐N
*Cold sores/herpes	☐Y ☐N	Dementia	☐Y ☐N		
*Hepatitis, type: _____	☐Y ☐N	Autoimmune condition	☐Y ☐N	Type: _____	
*HIV/AIDS	☐Y ☐N				
*Organ transplant: _____	☐Y ☐N	Cancer	☐Y ☐N	Type: _____	
*Pacemaker/Defibrillator	☐Y ☐N	(other than skin)			
*Staph bacterial infection	☐Y ☐N	Radiation treatment	☐Y ☐N	When & why: _____	
*MRSA infection	☐Y ☐N				
*Vasovagal reaction (fainting)	☐Y ☐N	**SURGICAL PROCEDURES (within the past 2 years):** _____			
*Premedication prior to procedures	☐Y ☐N				
Antibiotic:_____		_____			
*Accutane use in the last 6 months	☐Y ☐N				

***Have you had MELANOMA SKIN CANCER?** ☐Y ☐N Location(s) & date(s):_____

Have you had BASAL CELL CARCINOMA? ☐Y ☐N Location(s) & date of most recent: _____

Have you had SQUAMOUS CELL CARCINOMA? ☐Y ☐N Location(s) & date of most recent: _____

Do you wear Sunscreen? SPF _____ ☐Y ☐N

Has anyone in your FAMILY HAD MELANOMA? ☐Y ☐N Which relative(s): _____

Are you ALLERGIC to:

*Adhesive	☐Y ☐N
*Epinephrine	☐Y ☐N
*Lidocaine	☐Y ☐N
*Antibiotic ointment	☐Y ☐N
*Latex	☐Y ☐N

ALLERGIES TO MEDICATIONS:

_____

_____

_____

SOCIAL HISTORY:

Alcohol use:
☐ None
☐ < 1 drink a day
☐ 1-2 drinks daily
☐ 3 or more per day

Cigarette smoking:
☐ Never smoked
☐ Former smoker
☐ Currently smoke

List all CURRENT MEDICATIONS
(including chemotherapy, over-the-counter medications, vitamins, herbal supplements):

_____

_____

REVIEW OF SYSTEMS (Check any *CURRENT* SYMPTOMS or CONDITIONS):

*Pregnant	☐Y ☐N	*Problems w/bleeding/blood thinner	☐Y ☐N	
*Planning pregnancy	☐Y ☐N	Recent illness (past 3 months)	☐Y ☐N	Describe _____
*Currently breastfeeding	☐Y ☐N	Abnormal blood counts	☐Y ☐N	
*Recent biologic med.	☐Y ☐N	Abnormal scarring	☐Y ☐N	
*Recent chemotherapy	☐Y ☐N	Enlarged lymph nodes	☐Y ☐N	
*Immunosuppression	☐Y ☐N	Fever or chills	☐Y ☐N	

Patient Signature _____ **Date** _____ **Dr Initials** _____ **Staff Initials**_____ v12.2015