VALLEY DERMATOLOGY SPECIALISTS

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Intake and History Form

Name: _____ Date: _____

Street Address: _____ City / State: _____

Zip Code: _____ Date of Birth: _____Gender: _____

Phone Number (day): _____Phone Number (Night): _____

Email Address: _____ Social Security: _____

Emergency Contact: _____ Relationship:_____

Phone: _____

Preferred Language: _____Race: _____Ethnic Group: _____

Referring Physician: _____Phone: _____

Primary Care Physician: _____Phone: _____

Address: _____City or Zip Code: _____

Primary Insurance Holder Name: _____DOB: _____

Address: _____

Insurance Name: _____Member ID:_____ Group #:_____

Insurance Phone Number: _____

Relation to Patient: _____

Secondary or Supplemental Insurance: _____

_____ Insurance Name: _____Member ID:_____

_____ Group #:_____ Insurance Phone Number: _____

_____

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Pharmacy Name: _____

Address:_____

Phone Number: _____

**** "Failure to provide pharmacy information may result in a delay of prescriptions"**

Past Medical History

Select any of the following medical conditions you currently have:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/ AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ **NONE**
- ☐ Other
- ☐ _____
- ☐ _____

Past Surgical History

Have you had any surgeries on the following organs?

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast: Breast Biopsy
- ☐ Breast: Breast Lumpectomy (Right, Left, Bilateral)
- ☐ Breast: Breast Mastectomy (Right, Left, Bilateral)
- ☐ Colon (Colectomy): Colon Cancer Resection
- ☐ Colon (Colectomy): Diverticulitis
- ☐ Colon (Colectomy): Inflammatory Bowel Disease
- ☐ Colon (Colectomy): Colostomy
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Joint Replacement: Hip (Right, Left, Bilateral)
- ☐ Joint Replacement: Knee (Right, Left, Bilateral)
- ☐ Kidney: Kidney Biopsy
- ☐ Kidney: Kidney Stone Removal
- ☐ Kidney: Kidney Transplant
- ☐ Kidney: Nephrectomy
- ☐ Liver: Hepatectomy
- ☐ Liver: Liver Transplant
- ☐ Liver Shunt
- ☐ Ovaries (Oophorectomy): Endometriosis
- ☐ Ovaries (Oophorectomy): Ovarian Cancer

- ☐ Ovaries:Tubal Ligation
- ☐ Pancreas:Pancreatectomy
- ☐ Prostate (Prostatectomy): Prostate Biopsy
- ☐ Prostate (Prostatectomy): TURP
- ☐ Prostate (Prostatectomy): APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Spleen (Splenectomy)
- ☐ Testicles (Orchiectomy)
- ☐ Uterus (Hysterectomy): Fibroids
- ☐ Uterus (Hysterectomy): Uterine Cancer
- ☐ Uterus (Hysterectomy): Cervical Cancer
- ☐ **NONE**
- ☐ Other
- ☐ _____
- ☐ _____

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Skin Disease History

Have you had any of the following?

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

- ☐ Mother
- ☐ Father
- ☐ Sister
- ☐ Brother
- ☐ Daughter
- ☐ Son
- ☐ Uncle
- ☐ Aunt
- ☐ Nephew
- ☐ Niece
- ☐ Grandmother
- ☐ Grandfather
- ☐ Grandson
- ☐ Granddaughter
- ☐ Other
- ☐ _____
- ☐ _____

Medications

List all current medications:

Allergies to Medications:

List all allergies and reactions if known:

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Smoking Status (please choose one)

- ☐ Current, Every Day Smoker
- ☐ Current, Some Day Smoker
- ☐ Former Smoker
- ☐ Never Smoker
- ☐ Unknown if Ever Smoked

Start Smoking (mm/dd/yyyy): _____
Quit Smoking (mm/dd/yyyy): _____

Number of Packs Per Day: _____ Total Years Smoking: _____

Alcohol Intake (please choose one):

- ☐ None
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day
- ☐ Other: _____

How often do you exercise?

- ☐ Once a day
- ☐ Several times a day
- ☐ A few times a week
- ☐ A few times a month

What is your caffeine use?

- ☐ Unspecified
- ☐ Several times a day
- ☐ Once a day
- ☐ A few times a week
- ☐ A few times a month
- ☐ Other: _____
- ☐ Never

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Advance Care (QM47)

Do you have a health care proxy in the event you are unable to make your own medical decisions?

- ☐ Yes
- ☐ No

Have you had your influenza vaccination within the last year?

- ☐ Yes
- ☐ No

Have you had your pneumonia vaccination?

- ☐ Yes
- ☐ No