ONSPOT DERMATOLOGY

Date:_____ **DOB:** _____ **MRN:** _____

Patient Name: _____

Referring Provider: _____

MEDICATION ALLERGIES: _____

_____

Pharmacy Name: _____ **Pharmacy Phone Number:** _____

Pharmacy Address: _____

MEDICAL HISTORY AND INTAKE FORM

Past Medical History: (Please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial Fibrillation (Irregular Heartbeat)
Bone Marrow Transplant
BPH (Enlarged Prostate)
Cancer: Type(s)_____

_____

_____

COPD (Chronic Obstructive Pulmonary Disease)
Coronary Artery Disease
Depression
Diabetes
End Stage Renal (Kidney) Disease
GERD (Acid Reflux)
Hearing Loss
Hepatitis/Liver Disease
Hypertension (High Blood Pressure)
HIV/AIDS

Hypercholesterolemia (High Cholesterol)
Hyperthrroid (Overactivce Thyroid)
Hypothyroid (Underactive Thyroid)
Radiation Treatment
Seizures
Stroke
None
Other: _____

_____

Past Surgical History: (Please circle all that apply)

Appendix (Appendectomy)
Bladder (Cystectomy)
Breast: Lumpectomy (Both Breasts)
Breast: Lumpectomy (Left Breasts)
Breast: Lumpectomy (Right Breasts)
Breast: Mastectomy (Both Breasts)
Breast: Mastectomy (Left Breasts)
Breast: Mastectomy (Right Breasts)
Breast: Breast Biopsy
Colon (Colectomy): Colon Cancer Resection
Colon (Colectomy): Inflammatory Bowel Disease
Colon: Colostomy
Gall Bladder (Cholecystectomy): Removed
Heart: Coronary Artery Bypass Surgery
Heart: PTCA (Coronary Angioplasty)
Heart: Mechanical valve Replacement
Heart: Biological Valve Replacement
Heart: Heart Transplant

Joint Replacement: Knee (Both)
Joint Replacement: Knee (Left)
Joint Replacement: Knee (Right)
Joint Replacement: Hip (Both)
Joint Replacement: Hip (Left)
Joint Replacement: Hip (Right)
Kidney: Kidney Biopsy
Kidney: Nephrectomy
Kidney: Kidney Stone Removal
Kidney: Kidney Transplant
Liver: Shunt
Liver: Liver Transplant
Liver: Hepatectomy
Ovaries(Oophorectomy): Endometriosis
Ovaries(Oophorectomy): Ovarian Cyst
Ovaries(Oophorectomy): Ovarian Cancer
Ovaries: Tubal Ligation

Pancreas: Pancreatecomy
Prostate(Prostatectomy): Postate Cancer
Prostate(Prostatectomy): Prostate Biopsy
Prostate: TURP (Transurethral Resection of the Prostate)
Rectum: APR (Abdominoperineal Resection)
Rectum: Lower Anterior Resection
Skin: Biopsy
Skin: Basal Cell Carcinoma
Skin: Melanoma
Spleen (Splenectomy)
Testicles (Orchiectomy)
Uterus (Hysterectomy): Fibroids
Uterus (Hysterectomy): Uterine Cancer
Uterus (Hysterectomy): Cervical Cancer

Other: _____

*****Please fill in reverse side of sheet also*****

Skin Disease History: (Please circle all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratosis (pre-cancerous lesions)	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Squamous Cell Cancer
Blistering Sun Burns	Melanoma	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? If yes, which relative(s)? _____

Family History: (Please Circle all that apply)

Ance	Mother	Father	Sister	Brother	Daughter	Son	Other	None
Arthritis	Mother	Father	Sister	Brother	Daughter	Son	Other	None
Asthma	Mother	Father	Sister	Brother	Daughter	Son	Other	None
Diabetes	Mother	Father	Sister	Brother	Daughter	Son	Other	None
Eczema	Mother	Father	Sister	Brother	Daughter	Son	Other	None
Hay Fever/Allergies	Mother	Father	Sister	Brother	Daughter	Son	Other	None
Lupus	Mother	Father	Sister	Brother	Daughter	Son	Other	None
Psoriasis	Mother	Father	Sister	Brother	Daughter	Son	Other	None
Non-Melanoma Skin Cancers	Mother	Father	Sister	Brother	Daughter	Son	Other	None

Review of Systems: Do you have or are you currently experiencing any of the following (Please circle Yes or No)

Changing mole	Yes	No	Muscle weakness	Yes	No
Rash	Yes	No	Neck stiffness	Yes	No
Fever or chills	Yes	No	Headaches	Yes	No
Depression	Yes	No	Seizures	Yes	No
Anxiety	Yes	No	Cough	Yes	No
Problems with healing	Yes	No	Shortness of Breath	Yes	No
Problems with bleeding	Yes	No	Wheezing	Yes	No
Problems with scarring (hypertrophic	Yes	No	Pacemaker	Yes	No
or keloid)	Yes	No	Defibrilator	Yes	No
Immunosuppression	Yes	No	Blood thinners	Yes	No
Hay Fever	Yes	No	GI upset with antibiotics	Yes	No
Chest Pain	Yes	No	Allergy to adhesive	Yes	No
Night sweats	Yes	No	Allergy to lidocane	Yes	No
Unintentional Weight Loss	Yes	No	Allergy to topical antibiotic ointments	Yes	No
Thyroid Problems	Yes	No	Artificial heart valve	Yes	No
Sore Throat	Yes	No	Artificial joint within the past 2 years	Yes	No
Blurry vision	Yes	No	MRSA	Yes	No
Abdominal pain	Yes	No	Premedication prior to procedures	Yes	No
Bloody stool	Yes	No	Rapid heartbeat with epinephrine	Yes	No
Bloody urine	Yes	No	Pregnancy or planning a preganancy	Yes	No
Joint aches	Yes	No	Nursing	Yes	No

Immunizations: Have you had the following immunizations?

Vaccine:	**Date of Vaccination (can be approximate if unsure)**
Influenza (Flu)	_____
Pneumonia	_____
Varicella (Shingles)	_____