DERMATOLOGY SPECIALISTS OF ILLINOIS

History and Intake Form

PATIENT INFORMATION

Name: ______________________ DOB: ______________________

Preferred Pharmacy: ______________________ City: ______________________

Email: ______________________

Preferred Language: English Spanish Other: ________

Emergency Contact- Name/Relation: ______________________ Phone: ______________________

Primary Care Physician: ______________________ **City** ______________________

Past Medical History: (please ☑ all that apply)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Bone Marrow Transplant
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis (A, B or C)
- ☐ High Blood pressure
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Elevated Thyroid
- ☐ Underactive Thyroid
- ☐ Leukemia
- ☐ ADHD
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ NONE

Other ______________________

Past Surgical History: (please ☑ all that apply)

- ☐ Appendix Removed
- ☐ Bladder Removed
- ☐ Mastectomy (Right, Left, Bilateral)
- ☐ Lumpectomy (Right, Left, Bilateral)
- ☐ Breast Biopsy (Right, Left, Bilateral)
- ☐ Breast Reduction
- ☐ Breast Implants
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Colonoscopy Date: ____________
- ☐ Gallbladder Removed
- ☐ Coronary Artery Bypass
- ☐ Mammogram Date: ____________
- ☐ Mechanical Valve Replacement
- ☐ Biological Valve Replacement
- ☐ Heart Transplant
- ☐ Joint Replacement, Knee (Right, Left, Bilateral) YEAR: ________
- ☐ Joint Replacement, Hip (Right, Left, Bilateral) YEAR: ________
- ☐ Joint Replacement within last 2 years
- ☐ Joint Replacement within last 2 years
- ☐ Kidney Biopsy (Nephrectomy)
- ☐ Kidney Removed (Right, Left)
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Ovaries Removed: Endometriosis
- ☐ Ovaries Removed: Cyst
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ PAP Smear - Date: ____________
- ☐ Prostate Removed: Prostate Cancer
- ☐ Prostate Biopsy
- ☐ TURP (Prostate Removal)
- ☐ Spleen Removed
- ☐ Testicles Removed (Right, Left, Bilateral)
- ☐ Hysterectomy: Fibroids
- ☐ Hysterectomy: Uterine Cancer
- ☐ Hysterectomy: OTHER

Other

____

____

Skin Disease History: (please ☑ all that apply)

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Poison Ivy
- ☐ Precancerous Mole
- ☐ Psoriasis
- ☐ Squamous Cell Date: ____________
- ☐ Basal Cell Date: ____________
- ☐ Melanoma Date: ____________

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 skin cancer? Yes No If yes, Circle: -Melanoma -Basal Cell -Squamous Cell

If yes, which relative(s)? ____________________________________

Medications: (Please enter all current medications or attach current medication list)

____

____

____

Allergies: (Please enter all allergies) Latex Allergy: Yes or No

____

____

ALERTS: (please ☑ all that apply)

- ☐ Allergy to Adhesive
- ☐ Allergy to Lidocaine
- ☐ Allergy to topical antibiotics
- ☐ Artificial heart valve
- ☐ Artificial joint replacement
- ☐ Blood thinners
- ☐ Defibrillator
- ☐ MRSA
- ☐ Pacemaker
- ☐ Require antibiotics prior to a surgical procedure
- ☐ Rapid heart beat with epinephrine
- ☐ Are you pregnant or currently trying to get pregnant?

Social History: (Please ☑ all that apply)

Cigarette Smoking:

- ☐ Currently Smokes How many packs per day? __________ For how many years? __________
- ☐ Never smoked
- ☐ Former Smoker

Review of Systems: Are you currently experiencing any of the following?

YES	NO		YES	NO		YES	NO	
☐	☐	Problems with bleeding	☐	☐	Night sweats	☐	☐	Muscle weakness
☐	☐	Problems with healing	☐	☐	Unintentional weight loss	☐	☐	Neck Stiffness
☐	☐	Problems with scarring	☐	☐	Thyroid problems	☐	☐	Headaches
☐	☐	Rash	☐	☐	Sore throat	☐	☐	Seizures
☐	☐	Immunosuppression	☐	☐	Blurry Vision	☐	☐	Cough
☐	☐	Hay fever	☐	☐	Abdominal Pain	☐	☐	Shortness of breath
☐	☐	Chest pain	☐	☐	Blood stool/urine	☐	☐	Wheezing
☐	☐	Fever or Chills	☐	☐	Joint Aches	☐	☐	Anxiety/Depression

If you are **65 or older**, please answer the following questions:

Have you had your pneumonia vaccine?	☐ YES	☐ NO
Do you have a living will?	☐ YES	☐ NO
If you are unable to make your own medical decisions, do you have someone appointed to make those decisions for you?	☐ YES	☐ NO