

Oahu Dermatology LLC – Intake and History Form

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Name: _____ Date of Birth: _____

Referring Physician (if any): _____ PCP: _____

Email Address (please print): _____

May we leave detailed messages regarding your health care, services, and appointment reminders on your answering machine? YES NO Can we send you emails regarding special promotions? YES NO

Preferred Pharmacy (example: Long's Makiki) Name: _____

What is the reason for your visit today? _____

Past Medical History (select any of the following medical conditions you currently have:

- | | | |
|---|--|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> GERD/ Reflex Disease | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bone Marrow Transplant | <input type="checkbox"/> Hypertension | <input type="checkbox"/> NONE |
| <input type="checkbox"/> Benign Prostatic Hypertrophy | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Hypercholesterolemia | _____ |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Hyperthyroidism | |
| <input type="checkbox"/> COPD/ Lung Disease | <input type="checkbox"/> Hypothyroidism | |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Leukemia | |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Lung Cancer | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lymphoma | |

Past Surgical History Have you had any surgeries on the following organs?

- | | |
|--|--|
| <input type="checkbox"/> Appendix | <input type="checkbox"/> Liver transplant |
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Liver – shunt |
| <input type="checkbox"/> Breast Biopsy | <input type="checkbox"/> Ovaries – endometriosis |
| <input type="checkbox"/> Breast Lumpectomy (R, L, bilateral) | <input type="checkbox"/> Ovaries – ovarian cancer |
| <input type="checkbox"/> Breast Mastectomy (R, L, bilateral) | <input type="checkbox"/> Ovaries – ovarian cyst |
| <input type="checkbox"/> Colon Cancer Resection | <input type="checkbox"/> Ovaries – tubal ligation |
| <input type="checkbox"/> Colon (diverticulitis) | <input type="checkbox"/> Pancreas – pancreatectomy |
| <input type="checkbox"/> Colon (inflammatory bowel disease) | <input type="checkbox"/> Prostate Biopsy |
| <input type="checkbox"/> Colon (colostomy) | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Gallbladder (Cholecystectomy) | <input type="checkbox"/> Prostate: TURP |
| <input type="checkbox"/> Heart: Coronary Artery Bypass Surgery | <input type="checkbox"/> Rectum – abdominal perineal resection |
| <input type="checkbox"/> Heart Transplant | <input type="checkbox"/> Rectum – low anterior resection |
| <input type="checkbox"/> Heart: Mechanical Valve Replacement | <input type="checkbox"/> Skin – Basal Cell Carcinoma |
| <input type="checkbox"/> Heart: PTCA (angioplasty) | <input type="checkbox"/> Skin - Squamous Cell Carcinoma |
| <input type="checkbox"/> Hip Replacement (R, L, bilateral) | <input type="checkbox"/> Skin – Melanoma |
| <input type="checkbox"/> Knee Placement (R, L, bilateral) | <input type="checkbox"/> Spleen |
| <input type="checkbox"/> Kidney Biopsy | <input type="checkbox"/> Testicles |
| <input type="checkbox"/> Kidney Stone Removal | <input type="checkbox"/> Uterus (fibroids, uterine cancer, cervical cancer) |
| <input type="checkbox"/> Kidney Transplant | <input type="checkbox"/> NONE |
| <input type="checkbox"/> Kidney – nephrectomy | <input type="checkbox"/> Other |
| <input type="checkbox"/> Liver – hepatectomy | |

Skin Disease History

Have you had any of the following?

- Acne
- Actinic Keratoses (pre-cancers)
- Asthma
- Basal Cell Carcinoma
- Blistering Sunburns
- Dry Skin
- Eczema
- Flaking / Itchy Scalp
- Hay Fever / Allergies
- Melanoma
- Poison Ivy
- Precancerous Moles
- Psoriasis
- Squamous Cell Carcinoma
- NONE
- Other _____

Do you wear sunscreen?

- YES
- NO
- If yes, what SPF? _____

Do you have a family history of Melanoma?

YES NO If yes, which relative?

- Mother
- Father
- Sister
- Brother
- Daughter
- Son
- Uncle
- Aunt
- Nephew
- Niece
- Other _____

Use of tanning beds?

- Currently
- Previously
- Never

Medications (list all current medications): _____

Allergies (please specify your allergy and reaction): No known drug allergies

Social History

Smoking Status: Current every day smoker Current some day smoker Former smoker Never

Number of packs per day: _____ Total years smoking: _____

Alcohol Intake: 3 or more per day 1-2 per day 1 or less per day None

Occupation: _____

Family Medical History (only include immediate family):

- Acne
- Basal Cell/Squamous Cell Carcinoma
- Eczema
- Psoriasis
- Bleeding Disorders
- Other Cancers: _____

Review of Systems (pertaining to yourself)

Please check YES or NO if you have experienced any of the following within the last 30 days:

Symptom	Yes	No
Problems with bleeding		
Problems with healing		
Problems with scarring (hypertrophic / keloid)		
Rash		
Immunosuppression		
Hay fever		
Chest pain		
Fever or chills		
Night Sweats		
Unintentional weight loss		
Thyroid problems		
Sore throat		
Blurry Vision		
Abdominal pain		
Bloody stool		
Bloody urine		
Joint aches		
Muscle weakness		
Neck stiffness		
Headaches		
Seizures		
Shortness of breath		
Wheezing		
Anxiety		
Depression		

Alerts

Symptom	Yes	No
Allergy to adhesive		
Allergy to lidocaine		
Allergy to topical antibiotic ointments		
Artificial heart valve		
Artificial joints within past two years		
Blood thinners		
Defibrillator		
MRSA		
Pacemaker		
Premedication prior to procedures		
Rapid heartbeat with epinephrine		
Pregnancy or planning a pregnancy		