Alexandria ASSOCIATES IN DERMATOLOGY

HISTORY & INTAKE FORM

(PLEASE PRINT)

Patient: ______________________________ Date of Birth: ____/____/____

Primary Care Physician: ______________________________ Occupation: ______________________________

Pharmacy & Pharmacy Address: ______________________________

Past Medical History/Alerts: (Please circle all that apply)

ALERTS:

- Artificial Joint
- Artificial Heart Valve
- Blood Thinners
- Defibrillator
- GI Upset w/ Antibiotics
- HIV/Hepatitis
- Immunosuppressant
- Pacemaker
- Pre-meds Prior to Procedure
- Pregnant/Nursing
- Yeast Infection w/ Antibiotics

MEDICAL HISTORY

- Anxiety
- Arthritis
- Rheumatoid Psoriatic 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
- HIV/AIDS
- Hyper or Hypotension
- Hypercholesterolemia
- Hyper or Hypothyroidism
- Leukemia
- Lung Cancer
- Lymphoma
- Polycystic Ovarian Disease
- Ovaries Removed
- Prostate Cancer
- Prostate Issues
- Radiation Treatment
- Seizures
- Stroke
- None

Other: ______________________________

Social History: (Please circle all that apply)

- Current Smoker
  - Daily
  - Not Daily
- Has smoked in the past
- Has never smoked

- Alcohol
- Social Only
- < 1 drink daily
- 1-2 drinks daily
- ≥ 3 drinks daily
- None

- Drug Use
- None
- Other:

____

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Skin Disease History: (Please circle all that apply)

- 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 Cancer

Other: ______________________________

PLEASE SEE BACK SIDE

Review of Systems: Are you currently experiencing any of the following? (Please circle all that apply)

Pregnancy or Planning
Breastfeeding or Lactation
Allergy to numbing agents
Problems with bleeding
Problems with healing
Problems with scarring
Yeast Infections with Antibiotics
GI Upset with Antibiotics
Immunosupression

Major Surgeries:

Hysterectomy
Joint Replacement
Mitral Valve Replacement
Kidney Surgeries
Mastectomy
Breast Surgeries
Other:
____
____

Family History:

High Blood Pressure
High Cholesterol
Diabetes
Lupus
Psoriasis
Melanoma
Cancers:
Type:________________________
Family Member: _______________

Medications:

(Please enter all current medications)

____
____
____

Allergies

(Please enter all allergies and associates reactions)

____
____
____

______ Patient Initials
_____/_____/_____ Date