

San Luis Dermatology & Laser Clinic, Inc.

Patient Name: _____ DOB: _____

Pharmacy Name: _____ LOCATION _____

Primary Care physician: _____ City: _____

Health History Intake Form

The federal government has defined a complete electronic medical record (EMR) or electronic health record (EHR) as containing four basic functions: computerized orders for prescriptions, computerized orders for tests, reporting of test results, and physician notes.

In 2009, as a part of the Economic Stimulus, the federal government began offering incentives to providers to encourage implementation of electronic health records.

Providers must attest to demonstrating “meaningful use” **every year** to avoid payment adjustment. Providers have to show that they are “meaningfully using” their EHRs by meeting thresholds for a number of objectives.

As part of the objectives we are asked to have our patients complete medical history questions, and demographics so that we may eventually qualify for “meaningful use”.

Thank you for your cooperation in completing this information.

Past Medical History: (please all that apply)

- | | |
|------------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hypercholesterolemia |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> BPH | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Bone Marrow Transplantation | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Lung Cancer |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> GERD | <input type="checkbox"/> Valve Replacement |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> None of the above |
| <input type="checkbox"/> Hepatitis | |

Other _____

Reviewed by: MPH RJH CBF JWD Date: _____ Initials _____

Patient Name: _____ **DOB:** _____

Past Surgical History: (please all that apply)

- | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|
| <input type="checkbox"/> Appendix Removed(Appendectomy) | <input type="checkbox"/> Kidney Removed (Nephrectomy)
(Right, Left) |
| <input type="checkbox"/> Bladder Removed (Cystectomy) | <input type="checkbox"/> Kidney Stone Removal |
| <input type="checkbox"/> Mastectomy (<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both) | <input type="checkbox"/> Kidney Transplant |
| <input type="checkbox"/> Lumpectomy (<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both) | <input type="checkbox"/> Ovaries Removed: Endometriosis |
| <input type="checkbox"/> Breast Biopsy(<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both) | <input type="checkbox"/> Ovaries Removed: Cyst |
| <input type="checkbox"/> Breast Reduction | <input type="checkbox"/> Ovaries Removed: Ovarian Cancer |
| <input type="checkbox"/> Breast Implants | <input type="checkbox"/> Prostate Removed: Prostate Cancer |
| <input type="checkbox"/> Colectomy: Colon Cancer Resection | <input type="checkbox"/> Prostate Biopsy |
| <input type="checkbox"/> Colectomy: Diverticulitis | <input type="checkbox"/> TURP |
| <input type="checkbox"/> Colectomy: IBD | <input type="checkbox"/> Skin Biopsy |
| <input type="checkbox"/> Gallbladder Removed | <input type="checkbox"/> Basal Cell Cancer Surgery |
| <input type="checkbox"/> Coronary Artery Bypass | <input type="checkbox"/> Squamous Cell Carcinoma Surgery |
| <input type="checkbox"/> Percutaneous transluminal
coronary angioplasty (ptca) | <input type="checkbox"/> Melanoma Surgery |
| <input type="checkbox"/> Mechanical Valve Replacement | <input type="checkbox"/> Spleen Removed (splenectomy) |
| <input type="checkbox"/> Biological Valve Replacement | <input type="checkbox"/> Testicles Removed (Right, Left, Both) |
| <input type="checkbox"/> Heart Transplant | <input type="checkbox"/> Uterus (Hysterectomy): Fibroids |
| <input type="checkbox"/> Joint Replacement Knee (<input type="checkbox"/> Right <input type="checkbox"/> Left
<input type="checkbox"/> Both) | <input type="checkbox"/> Uterus (Hysterectomy): Uterine
Cancer |
| <input type="checkbox"/> Joint Replacement Hip (<input type="checkbox"/> Right
<input type="checkbox"/> Left <input type="checkbox"/> Both) | <input type="checkbox"/> None of the above |
| <input type="checkbox"/> Kidney Biopsy | |

Other _____

Skin Disease History: (please all that apply)

- | | |
|-------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Flaking or Itchy Scalp |
| <input type="checkbox"/> Actinic Keratoses | <input type="checkbox"/> Hay Fever/Allergies |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Melanoma |
| <input type="checkbox"/> Basal Cell Skin Cancer | <input type="checkbox"/> Poison Ivy |
| <input type="checkbox"/> Blistering Sunburns | <input type="checkbox"/> Precancerous Moles |
| <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Squamous Cell Skin Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> None of the above |

Other _____

Do you wear Sunscreen? Yes No SPF: _____

Do you tan in a tanning salon? Yes No

Patient Name: _____ **DOB:** _____

Family History:

Do you have a **family** history of Skin Cancer?

Basal Cell Carcinoma Yes No

Squamous Cell Carcinoma Yes No

Do you have a family history of **Melanoma**? Yes No

Mother

Son

Grandmother

Father

Uncle

Grandfather

Sister

Aunt

Grandson

Brother

Nephew

Granddaughter

Daughter

Niece

Other

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

Include Strength and dosage Example - Aspirin 81mg tablets 1 daily

_____	_____
_____	_____
_____	_____
_____	_____

Allergies to Medications: (Please enter all drug allergies & **reactions (i.e. rash)**)

Allergies: _____ Reactions _____

Allergies: _____ Reactions _____

ALERTS: (please Yes/No for the following)

Alerts:	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 procedure		
Rapid heartbeat with epinephrine		
Pregnancy or planning a pregnancy		
History of blood transfusions		

Patient Name: _____ **DOB:** _____

Social History: (please all that apply)

Smoking Status:

- Never smoked
- Quit: former smoker
- Smokes less than daily
- Smokes daily

Illicit Drug Use:

- Drug Use
- IV Drug Use

Alcohol Use (ETOH)

- Alcohol: none
- Alcohol: less than 1 drink a day
- Alcohol 1-2 drinks a day
- Alcohol: 3 or more drinks a day

Safety:

- I feel safe at home.
- I do not feel safe at home.

Birth Place:

City _____

State _____

Country _____

Other _____

Quality Measures – For patients 65 and older:

Vaccination Status: Have you received a pneumonia vaccination? **Yes** **No**

Advance Care

Do you have a health care proxy in the event you are unable to make your own medical decisions? **Yes** **No**

Do you have a living will: **Yes** **No**

Patient Name: _____ **DOB:** _____

Review of Systems: Are you **currently** experiencing any of the following?
(Please Yes/No for the following)

Symptom	Yes	No
Problem with bleeding		
Problems with healing		
Problems with scarring(hypertrophic or 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		
Cough		
Shortness of breath		
Wheezing		
Anxiety		
Depression		

Other Symptoms: _____

My Primary Care Physician is aware of my current Alerts & Symptoms Yes No

PATIENT SIGNATURE _____ Date: _____

Thank you!