

# 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)<br>(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<br>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<br><input type="checkbox"/> Both) | <input type="checkbox"/> Uterus (Hysterectomy): Uterine<br>Cancer      |
| <input type="checkbox"/> Joint Replacement Hip ( <input type="checkbox"/> Right<br><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

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> <b>Mother</b>   | <input type="checkbox"/> <b>Son</b>    | <input type="checkbox"/> <b>Grandmother</b>   |
| <input type="checkbox"/> <b>Father</b>   | <input type="checkbox"/> <b>Uncle</b>  | <input type="checkbox"/> <b>Grandfather</b>   |
| <input type="checkbox"/> <b>Sister</b>   | <input type="checkbox"/> <b>Aunt</b>   | <input type="checkbox"/> <b>Grandson</b>      |
| <input type="checkbox"/> <b>Brother</b>  | <input type="checkbox"/> <b>Nephew</b> | <input type="checkbox"/> <b>Granddaughter</b> |
| <input type="checkbox"/> <b>Daughter</b> | <input type="checkbox"/> <b>Niece</b>  | <input type="checkbox"/> <b>Other</b>         |

**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)

Tobacco Status:

- Never smoked
- Quit: former smoker
- Smokes less than daily
- Smokes daily
- Other forms of Tobacco – Chew, Pipe, Cigar etc.

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.

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**Quality Measures – For patients 65 and older ONLY:**

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**

Proxy Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Which statement best reflects your wishes on advanced care recommendations?

- Do Not Intubate:** I do not wish to have a breathing tube, even if it is necessary to save my life.
- Do Not Resuscitate:** If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it's necessary to save my life.
- Full Cardiopulmonary Resuscitation:** I want full cardiopulmonary resuscitation efforts to be made.

**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!*