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)

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

Other ____

Reviewed by: ☐ MPH ☐RJH ☐ CBF ☐ JWD Date: ________________Initials_______

Patient Name:______________________________________**DOB:**_________________________

Past Surgical History: (please ☑ all that apply)

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

Other____

Skin Disease History: (please ☑ all that apply)

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ 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**
- ☐ **Father**
- ☐ **Sister**
- ☐ **Brother**
- ☐ **Daughter**
- ☐ **Son**
- ☐ **Uncle**
- ☐ **Aunt**
- ☐ **Nephew**
- ☐ **Niece**
- ☐ **Grandmother**
- ☐ **Grandfather**
- ☐ **Grandson**
- ☐ **Granddaughter**
- ☐ **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)

____

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____

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!