San Luis Dermatology & Laser Clinic, Inc.

Patient Name: _____ DOB: _____

Pharmacy Name:_____ LOCATION_____

Primary Care physician: _____ City:_____

Health History Intake Form

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 ☐ CFK

Date: _____ Provider's Initials_____

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) Date: _____
- ☐ Joint Replacement Hip (☐Right ☐Left ☐ Both) Date: _____
- ☐ 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 (Location & Date) _____
- ☐ 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

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 and Month/Year.

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		

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

All patients:

MIPS Measure #110 Preventive Care and Screening

Have you had your influenza immunization? ☐ **Yes** ☐ **No**

Patients 50 and over ONLY:

MIPS Measure #474 Zoster (Shingles) Vaccination

Have you had the Shingrix vaccine? ☐ **Yes** ☐ **No**
*2 dose vaccine

Quality Measures – For patients 65 and older ONLY:

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.

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: _____

PATIENT SIGNATURE_____ Date:_____

Thank you!