San Luis Dermatology, Inc.

Patient Name: _____ DOB: _____

Pharmacy Name:_____ LOCATION_____

Primary Care physician: _____ City:_____

Health History Intake Form

Past Surgical History: (please ☑ all that apply)

☐ Joint Replacement Knee ☐Right ☐Left ☐Both
Date:_____
☐ Joint Replacement Hip ☐Right ☐Left ☐Both
Date:_____
☐ Valve Replacement
Date:_____
☐ Skin Biopsy
☐ Basal Cell Cancer Surgery
☐ Squamous Cell Carcinoma Surgery
☐Melanoma Surgery (Location & Date)
_____
☐ None of the above

Skin Disease History: (please ☑ all that apply)

☐ Actinic Keratoses
☐ Basal Cell Skin Cancer
☐ Hay Fever/Allergies
☐ Melanoma (where/when?)
☐ Precancerous Moles
☐ 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**	☐ **Brother**	☐ **Grandmother**
☐ **Father**	☐ **Daughter**	☐ **Grandfather**
☐ **Sister**	☐ **Son**	☐ **Other**

Social History: (please ☑ all that apply)

Tobacco Status:

- ☐ Never smoked
- ☐ Quit: former smoker (answer below)
  a. Started Smoking _____
  b. Quit Smoking _____
  c. Number of packs per day _____
- ☐ Total years of smoking _____
- ☐ Smokes less than daily
- ☐ Smokes daily
- ☐ Other forms of Tobacco – Chew, Pipe, Cigar etc.

Medications: (Please enter all current medications, or attach a separate legible list) *Please Include Strength, Form, and Dosage* Example – Aspirin, 81mg, tablet, 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		

Quality Measures – For patients 65 and older ONLY:

Advance Care Plan:

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 SIGNATURE_____ Date:_____

Reviewed by: MPH ☐ CBF ☐ JWD ☐ CFK ☐ TKW ☐

Date: _____ Provider's Initials_____