Dermatology ASSOCIATES of Northern Kentucky

Patient Visit History and Intake Form at Time of Appointment

Today's Date: _____

Patient Information:
Patient Name (include first, middle initial, last): _____

Date of Birth: _____

Were you referred? ☐ Yes ☐ No

Referring Physician Name and Fax # _____

_____

Reason for today's visit:

_____

Past Medical History: (please select all that apply)

☐ NONE
☐ Anxiety Disorder
☐ Arthritis
☐ Asthma
☐ Atrial Fibrillation
☐ Benign Prostatic Hyperplasia (BPH)
☐ Cerebrovascular Accident (Stroke)
☐ Chronic Obstructive Lung Disease (COPD)
☐ Coronary Arteriosclerosis (Coronary Artery Disease)
☐ Depressive Disorder (Depression)
☐ Diabetes Mellitus
☐ End Stage Renal Failure (Kidney Disease)
☐ Epilepsy (Seizures)
☐ Gastroesophageal Reflux Disease (GERD)
☐ Hypertension (High Blood Pressure)
☐ Hearing Loss
☐ Human Immunodeficiency Virus Infection (HIV)
☐ Hypercholesterolemia (High Cholesterol)
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Inflammatory Disease of Liver (Liver Disease)
☐ Leukemia
☐ Malignant Tumor of Breast
☐ Malignant Tumor of Colon
☐ Malignant Tumor of Lung
☐ Malignant Tumor of Prostate
☐ Radiation Therapy
☐ Bone Marrow Transplant

Other _____

Past Surgical History: (please select all that apply)

☐ NONE
☐ Appendectomy
☐ Biopsy of Breast
☐ Biopsy of Prostate
☐ Cystectomy (Bladder Removal)
☐ Cholecystectomy (Gallbladder Removal)
☐ Coronary Artery Bypass Graft
☐ Colectomy (Colon Removal)
☐ Mastectomy (Breast Surgery)
☐ History of Orchiectomy (Testicles)
☐ Coronary Angioplasty
☐ Heart Valve replacement
☐ Hysterectomy (Uterus)
☐ Kidney Biopsy
☐ Kidney Stone
☐ Oophorectomy (Ovaries Removed)
☐ Pancreatectomy (Pancreas)
☐ Prostatectomy (Removal of Prostate)
☐ Splenectomy (Spleen)
☐ Total Nephrectomy (Removal of Kidney)
☐ Hip Replacement (Left Hip Joint)
☐ Knee Replacement (Left Knee Joint)
☐ Hip Replacement (Right Hip Joint)
☐ Knee Replacement (Right Knee Joint)
☐ Transplant of Kidney
☐ Transplant of Heart
☐ Transplant of Liver

Other _____

Skin Conditions: (please select all that apply)

☐ NONE
☐ Acne
☐ Actinic Keratoses
☐ Basal Cell Skin Cancer
Location _____ Year_____
☐ Contact Dermatitis due to
Poison Ivy
☐ Dry Skin
☐ Dysplastic Nevus of Skin
Abnormal Mole
☐ Eczema
☐ Seasonal Allergies/Hay
Fever
☐ Malignant Melanoma
☐ Psoriasis
☐ Rosacea
☐ Seborrheic Dermatitis of
Scalp
☐ Skin Tanning
☐ Squamous Cell Carcinoma
Location _____ Year_____
☐ Sunburn of Second Degree

Other _____

Do you wear Sunscreen? ☐ Yes ☐ No If yes, what SPF? _____
Do you tan in a tanning salon? ☐ Yes ☐ No
Do you have a family history of Melanoma? ☐ Yes ☐ No

If yes, which relative(s)? _____

Medications: (Please list all current medications, vitamins, herbs, and supplements, or attach a list)
☐ NONE

_____

_____

_____

_____

Circle any of the following products you take – aspirin, Advil/Motrin/Ibuprofen, Aleve/Naprosyn, vitamin E, fish oil, saw palmetto, garlic, ginger, gingko, ginseng.

Allergies: (Please list all allergies and the type of reaction you have to each one)

_____

_____

_____

☐ NONE

Social History: (Please select all that apply)

Cigarette Smoking:
☐ Currently Smokes
☐ Never smoked
☐ Former Smoker

Alcohol Use:
☐ None
☐ less than 1 drink per day
☐ 1-2 drinks per day
☐ 3 or more drinks per day

IMMUNIZATION HISTORY:
☐ Influenza
☐ Pneumonia
☐ Shingles
☐ COVID-19

Occupation: _____ Preferred Language: _____

Race: _____ Ethnic Group: ☐ non-Hispanic ☐ Hispanic

Pharmacy Information:

Preferred pharmacy Name: _____
Phone#: _____
Location/City: _____

Primary Care Physician Information:
Name: _____
Phone #: _____
Address: _____

Review of Systems: Are you currently experiencing any of the following?
(Please check yes or no for the following)

Today's Symptom	Yes	No
problems with bleeding		
problems with healing		
problems with scarring (hypertrophic or keloid)		
rash		
immunosuppression		
skin concerns _____		

ALERTS: (please select all that apply)

☐ Allergy to Adhesive
☐ Allergy to latex
☐ Allergy to lidocaine
☐ Allergy to topical antibiotics
☐ Artificial heart valve
☐ Artificial joint replacement
☐ Blood thinners
☐ Defibrillator
☐ Pacemaker
☐ MRSA
☐ Require antibiotics prior to a surgical procedure
☐ Rapid heartbeat with epinephrine
☐ Females: Are you pregnant or currently trying to get pregnant?