Dermatology ASSOCIATES of Northern Kentucky

Patient Visit History and Intake Form

Please bring this form with you to your appointment. Please have insurance card. Please be prepared to also answer clinical questions at your visit regarding your current dermatological concern.

Today's Date: _____

Patient Information:

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

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)

☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Atrial fibrillation
☐ Bone Marrow Transplant
☐ Breast Cancer
☐ Colon Cancer
☐ COPD
☐ Coronary Artery Disease
☐ Depression
☐ Diabetes
☐ End Stage Renal Disease
☐ GERD
☐ Hearing Loss
☐ Hepatitis
☐ High Blood pressure
☐ HIV/AIDS
☐ High Cholesterol
☐ Hypothyroidism
☐ Hyperthyroidism
☐ Leukemia
☐ Lung Cancer
☐ Lymphoma
☐ Prostate Cancer
☐ Radiation Treatment
☐ Radiation/ X-Ray for acne treatment
☐ Seizures
☐ Stroke
☐ NONE

Other _____

Past Surgical History: (please select all that apply)

☐ Appendix Removed
☐ Bladder Removed
☐ Mastectomy (Right, Left, Bilateral)
☐ Lumpectomy (Right, Left, Bilateral)
☐ Breast Biopsy (Right, Left, Bilateral)
☐ Breast Reduction
☐ Breast Implants
☐ Colectomy: Colon Cancer Resection
☐ Colectomy: Diverticulitis
☐ Colectomy: IBD
☐ Gallbladder Removed
☐ Coronary Artery Bypass
☐ Mechanical Valve Replacement
☐ Biological Valve Replacement
☐ Heart Transplant
☐ Joint Replacement, Knee (Right, Left, Bilateral)
☐ Joint Replacement, Hip (Right, Left, Bilateral)
☐ Joint Replacement within last 2 years
☐ Kidney Biopsy (Nephrectomy)
☐ Kidney Removed (Right, Left)
☐ Kidney Stone Removal
☐ Kidney Transplant
☐ Ovaries Removed: Endometriosis
☐ Ovaries Removed: Cyst
☐ Ovaries Removed: Ovarian Cancer
☐ Prostate Removed: Prostate Cancer
☐ Prostate Biopsy
☐ TURP (Prostate Removal)
☐ Spleen Removed
☐ Testicles Removed (Right, Left, Bilateral)
☐ Hysterectomy: Fibroids
☐ Hysterectomy: Uterine Cancer

☐ NONE

Other _____

Skin Disease History: (please select all that apply)

☐ Acne
☐ Actinic Keratoses (precancer)
☐ Asthma
☐ Blistering Sunburns
☐ Basal Cell Skin Cancer
Most recent year_____
☐ Dry Skin
☐ NONE
☐ Eczema
☐ Flaking or Itchy Scalp
☐ Hay Fever/Allergies (jewelry, nickel, other)
☐ Melanoma
Site_____
Depth_____
Year_____
☐ Poison Ivy
☐ Precancerous Moles
☐ Psoriasis
☐ Rosacea
☐ Squamous Cell Skin Cancer
Most recent year_____

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 had to each)

_____

_____

_____

☐ 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

Occupation: _____ Preferred Language: _____

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

(If over age 60)
- ❑ Do you have a healthcare Proxy?
- ❑ Do you have a living will?

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 related to your dermatologic condition in which you are being evaluated for at your appointment today?
(Please check yes or no for the following)

Current Condition Symptoms	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?