Oahu Dermatology LLC – Intake and History Form

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Name: _____ Date of Birth: _____

Referring Physician (if any): _____ PCP: _____

Email Address (please print): _____

May we leave detailed messages regarding your health care, services, and appointment reminders on your answering machine? ☐ YES ☐ NO Can we send you emails regarding special promotions? ☐ YES ☐ NO

Preferred Pharmacy (example: Long's Makiki) Name: _____

What is the reason for your visit today? _____

Past Medical History (select any of the following medical conditions you currently have:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ Benign Prostatic Hypertrophy
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD/ Lung Disease
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD/ Reflex Disease
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ NONE
- ☐ Other _____
  _____

Past Surgical History Have you had any surgeries on the following organs?

- ☐ Appendix
- ☐ Bladder
- ☐ Breast Biopsy
- ☐ Breast Lumpectomy (R, L, bilateral)
- ☐ Breast Mastectomy (R, L, bilateral)
- ☐ Colon Cancer Resection
- ☐ Colon (diverticulitis)
- ☐ Colon (inflammatory bowel disease)
- ☐ Colon (colostomy)
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA (angioplasty)
- ☐ Hip Replacement (R, L, bilateral)
- ☐ Knee Placement (R, L, bilateral)
- ☐ Kidney Biopsy
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Kidney – nephrectomy
- ☐ Liver – hepatectomy
- ☐ Liver transplant
- ☐ Liver – shunt
- ☐ Ovaries – endometriosis
- ☐ Ovaries – ovarian cancer
- ☐ Ovaries – ovarian cyst
- ☐ Ovaries – tubal ligation
- ☐ Pancreas – pancreatectomy
- ☐ Prostate Biopsy
- ☐ Prostate Cancer
- ☐ Prostate: TURP
- ☐ Rectum – abdominal perineal resection
- ☐ Rectum – low anterior resection
- ☐ Skin – Basal Cell Carcinoma
- ☐ Skin - Squamous Cell Carcinoma
- ☐ Skin – Melanoma
- ☐ Spleen
- ☐ Testicles
- ☐ Uterus (fibroids, uterine cancer, cervical cancer)
- ☐ NONE
- ☐ Other

Skin Disease History

Have you had any of the following?

- ☐ Acne
- ☐ Actinic Keratoses (pre-cancers)
- ☐ Asthma
- ☐ Basal Cell Carcinoma
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking / Itchy Scalp
- ☐ Hay Fever / Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Carcinoma
- ☐ NONE
- ☐ Other _____

Do you have a family history of Melanoma?

☐ YES ☐ NO If yes, which relative?

- ☐ Mother
- ☐ Father
- ☐ Sister
- ☐ Brother
- ☐ Daughter
- ☐ Son
- ☐ Uncle
- ☐ Aunt
- ☐ Nephew
- ☐ Niece
- ☐ Other _____

_____

Do you wear sunscreen?

☐ YES ☐ NO If yes, what SPF? _____

Use of tanning beds?

☐ Currently ☐ Previously ☐ Never

Medications (list all current medications): _____

_____

_____

_____

Allergies (please specify your allergy and reaction): ☐ No known drug allergies

_____

Social History

Smoking Status: ☐ Current every day smoker ☐ Current some day smoker ☐ Former smoker ☐ Never

Number of packs per day: _____ Total years smoking: _____

Alcohol Intake: ☐ 3 or more per day ☐ 1-2 per day ☐ 1 or less per day ☐ None

Occupation: _____

Family Medical History (only include immediate family):

- ☐ Acne
- ☐ Basal Cell/Squamous Cell Carcinoma
- ☐ Eczema
- ☐ Psoriasis
- ☐ Bleeding Disorders
- ☐ Other Cancers: _____

Review of Systems (pertaining to yourself)

Please check YES or NO if you have experienced any of the following within the last 30 days:

Symptom	Yes	No
Problems with bleeding		
Problems with healing		
Problems with scarring (hypertrophic / 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		
Shortness of breath		
Wheezing		
Anxiety		
Depression		

Alerts

Symptom	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 procedures		
Rapid heartbeat with epinephrine		
Pregnancy or planning a pregnancy		