Oahu Dermatology LLC-Intake and History Form

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Name: _____ Date of Birth: _____

Referring Physician (if any): _____ PCP: _____

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 (ex: Long's Makiki Name): _____

What is the reason for your visit today? _____

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

- ☐ None
- ☐ Anxiety disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Chronic obstructive lung disease
- ☐ Depressive disorder
- ☐ Diabetes mellitus
- ☐ Elevated blood pressure
- ☐ End-stage renal disease
- ☐ H/O: hypertension
- ☐ Human immunodeficiency virus infection
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Inflammatory disease of liver
- ☐ Leukemia
- ☐ Malignant lymphoma (clinical)
- ☐ Malignant tumor of colon
- ☐ Other: _____

Past Surgical History Have you had any surgeries?

- ☐ None
- ☐ Excision of basal cell carcinoma
- ☐ Excision of melanoma
- ☐ Excision of squamous cell carcinoma
- ☐ History colectomy
- ☐ History of tissue graft heart replacement
- ☐ Mechanical heart valve replacement
- ☐ Total replacement of left hip joint
- ☐ Total replacement of left knee joint
- ☐ Total replacement of right hip joint
- ☐ Total replacement of right knee joint
- ☐ Other

Skin Disease History

Skin conditions:

- ☐ None
- ☐ Acne
- ☐ Actinic keratosis
- ☐ Dysplastic naevus of skin
- ☐ Eczema
- ☐ Psoriasis
- ☐ Sunburn of second degree
- ☐ Other: _____

Do you have a family history of Melanoma?

☐ YES ☐ NO If yes, which relative?

- ☐ None
- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Daughter
- ☐ Son
- ☐ Uncle
- ☐ Aunt
- ☐ Nephew
- ☐ Niece
- ☐ Grandmother
- ☐ Grandfather
- ☐ Grandson
- ☐ Granddaughter

Do you wear sunscreen?

☐ YES ☐ NO If yes, what SPF? _____

Medications (Please list all current medications): _____

Allergies (please specify your allergy and reaction):

Please check yes, if you have any allergies

☐ No known drug allergies
☐ Allergy to topical antibiotic ointments
☐ Allergy to adhesive
☐ Allergy to latex
☐ Allergy to lidocaine

Please specify if you have allergies to any other medications as well the reaction:_____

_____

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 (please 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	Symptom	Yes	No
Problems with bleeding			**New loss of taste or smell**		
Problems with healing			**Blurry Vision**		
Problems with scarring (hypertrophic or keloid)			**Abdominal pain**		
Rash			**Joint aches**		
Immunosuppression			**Muscle Weakness**		
Fever or Chills			**Headaches**		
Fatigue			**Cough**		
Unintentional weight loss			**Anxiety**		
Sore throat			**Depression**		

Alerts:

Name	Yes	No
Artificial heart valve placement		
Artificial joints within past two years		
Blood thinners		
Defibrillator		
MRSA		
Pacemaker		
Premedication prior to procedures		
Pregnancy or planning a pregnancy		