LAKE DERMATOLOGY
Medical Associates

Lake Dermatology Medical Associates, Inc.
History and Intake Form

Name:_____ **Date:**_____
Age: _____ **Sex:** M F **Referred by:** _____
e-mail address: _____
Main skin problem(s) you want evaluated:

_____
_____
_____

Review of Systems: Are you currently experiencing any of the following?
(Please circle problems that you are experiencing – or circle at bottom if none apply)

Problem	Problem	Other Problems Not Listed:
Problems with Bleeding	Bloody Stool	
Problems with Healing	Bloody Urine	
Problems with Scarring	Joint Aches	
Rash	Muscle Weakness	
Immunosuppression	Neck Stiffness	
Hay Fever	Headaches	
Chest Pain	Seizures	
Fever or Chills	Cough	
Night Sweats	Shortness of Breath	
Unintentional Weight Loss	Wheezing	
Thyroid Problems	Anxiety	
Sore Throat	Depression	
Blurry Vision		
Abdominal Pain		
Circle here if none apply!		

ALERTS: (please circle all that apply or circle at bottom if none apply)
Allergy to Adhesive
Allergy to lidocaine
Allergy to topical antibiotics
Artificial heart valve
Artificial joint replacement
Blood thinners
Defibrillator
Hepatitis
HIV/AIDS
MRSA (resistant staph. aureus infections)
Pacemaker
Require antibiotics prior to a surgical procedure
Rapid heart beat with epinephrine
Are you pregnant or currently trying to get pregnant?
Circle here if none of the above alerts apply!

Name:

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone Marrow Transplant
BPH
Breast Cancer
Colon Cancer
Congestive heart failure
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
High Blood pressure
HIV/AIDS
High Cholesterol
Kidney Issues
Leukemia
Liver Issues
Lung Cancer
Lymphoma
Multiple Sclerosis
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Thyroid Problems

NONE

Other _____

_____

Past Surgical History: (please circle 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: Inflammatory Bowel Disease
Gallbladder Removed
Coronary Artery Bypass
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replaced, Knee (Right, Left, Bilateral)
Joint Replaced, 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 (enlarged prostate treatment)
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer

NONE

Other _____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Other:
_____
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
_____
_____
Poison Oak
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer

NONE

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)? _____

Name:

Medications: (Please enter all current medications)

_____
_____
_____
_____
_____
_____
_____

Allergies: (Please enter all allergies)

_____
_____
_____

Social History:

Occupation:_____

Cigarette Smoking:

Currently Smoke: _____ cigarettes/day
Have smoked in the past for: _____ years
Never smoked

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

Family History Of: (Only first degree relatives) Please circle all that apply

None Melanoma Other Skin Cancer Eczema Diabetes Hay Fever Psoriasis Asthma
Hypertension Heart Disease Inflammatory Bowel Disease

Other family history: _____
_____

Preferred Language: _____

Race:_____ Ethnic Group:_____

Preferred pharmacy Name: _____

Phone#: _____

City or Zip code:_____