PITTSBURGHSKIN
DERMATOLOGY | MOHS SURGERY

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HISTORY & INTAKE FORM

Date: _____

Patient Name: _____ DOB:_____

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone Marrow Transplantation
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
Thyroid Problems
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke

NONE

Other:_____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: reason:_____
Gallbladder Removed
Coronary Artery Bypass
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral) date: _____
Joint Replacement, Hip (Right, Left, Bilateral) date:_____
Kidney Biopsy (Nephrectomy)
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: reason:_____
Prostate Removed: Prostate Cancer
TURP (Prostate Removal)
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: reason:_____
NONE

Other:_____

HISTORY & INTAKE FORM

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
NONE

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 enter all current medications)
_____
_____
_____
_____
_____

Allergies: (Please enter all allergies)
_____
_____

HISTORY & INTAKE FORM

Social History: (Please circle all that apply)

Cigarette Smoking:

Currently Smokes
Has smoked in the past
Never smoked
Former Smoker

Alcohol Use:

EtOH- None
EtOH- less than 1 drink per day
EtOH -1-2 drinks per day
EtOH -3 or more drinks per day

Other_____

Family History (Only first-degree relatives)

_____
_____
_____
_____
_____
_____

Preferred Language: _____

Race:_____ Ethnic Group:_____

Preferred pharmacy Name: _____

Phone#: _____

City or Zip code:_____

HISTORY & INTAKE FORM

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

Symptom	Yes	No
Problems with bleeding		
Problems with scarring (keloids)		
Problems with healing		
Rash		
Immunosuppression		
Hay Fever		
Chest pain		
Fever or chills		
Unintentional weight loss		
Thyroid problems		
Sore throat		
Blurry Vision		
Abdominal pain		
Headaches		
Joint Aches		
Bloody stool		
Bloody urine		

Other Symptoms:_____

ALERTS: (please circle all that apply)
Allergy to Adhesive
Allergy to lidocaine
Allergy to topical antibiotics
Artificial heart valve
Artificial joint replacement
Blood thinners
Defibrillator
MRSA
Pacemaker
Require antibiotics prior to a surgical procedure
Rapid heart beat with epinephrine
Are you pregnant or currently trying to get pregnant?

Patient/Guarantor Signature_____ Date:_____