PITTSBURGHSKIN
DERMATOLOGY | MOHS SURGERY

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Dr. Nicole F. Vélez, MD, FAAD, FACMS
Medical Director

HISTORY & INTAKE FORM

Date:_____

Name: _____ Date of Birth: _____ Sex: _____

Mailing address: _____

_____

Email address: _____ Permission to email? _____

Occupation: _____ Primary Care Doctor: _____

How did you hear about our office? _____

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial Fibrillation
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
NONE
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
High Blood Pressure
HIV/AIDS
High Cholesterol
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Hypothyroidism
Hyperthyroidism

Other:_____

Past Surgical History: (please circle all that apply)

Appendix Removed
Biological Valve Replacement
Bladder Removed
Breast Reduction
Breast Implants
Colectomy: Reason:_____
Coronary Artery Bypass
Gallbladder Removed
Heart Transplant
Hysterectomy: Reason:_____
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
Lumpectomy (Right, Left, Bilateral)
Mastectomy (Right, Left, Bilateral)
Mechanical Valve Replacement
Ovaries Removed: Reason:_____
Prostate Removed: Prostate Cancer
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
TURP (Prostate Removal)
NONE

Other:_____

Skin Disease History: (please circle all that apply)

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

Other:_____

Do you wear Sunscreen? Yes No
If yes, what SPF? _____
Do you tan at 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)

_____
_____
_____
_____
_____

Allergies: (Please list all allergies)

_____
_____

Immunizations: Have you had any of these immunizations recently?
____ Flu Shot ____ Pneumonia ____ Shingles

Social History: (Please circle all that apply)

Cigarette Smoking:
Current Smoker
Former Smoker
Never smoked
Cigar Smoker

Alcohol Use:
Do you drink alcohol? Yes No

How many times in the past year have you had 5 or more drinks in a day?
_____

Other_____
_____
_____

Family Medical History (Only first degree relatives):

_____
_____
_____

Preferred Language: _____

Race:_____ Ethnic Group:_____

Preferred Pharmacy:
Name: _____
Pharmacy Phone #: _____
Pharmacy City or Zip Code:_____

Insurance Policy Holder Information:

Name of Policy Holder: _____ Policy Holder's DOB: _____

Policy Holder Address (if not the same): _____

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
Betadine/Iodine Allergy
Blood thinners
Defibrillator
Latex Allergy
MRSA
Pacemaker
Require antibiotics prior to a surgical procedure
Rapid heart beat with epinephrine

Are you pregnant or trying to become pregnant? _____

Patient / Guarantor Signature _____ Date:_____