McDonnell Dermatology

Intake Form

Patient Name: ______________________________ **DOB:** ____________

Height: ___________ **Weight:** __________ **Pref. Language:** __________

Pharmacy ______________________________ **Pharmacy Phone:** ______________________________

Reason for today's visit: ____

Please circle the following medical conditions that you have:

Arthritis	COPD/Emphysema	Hepatitis A B C	Stroke
Asthma	Coronary Artery Disease	HIV/AIDS	Seizures
Atrial Fibrillation (AFIB)	Diabetes	Thyroid Disease	Depression
	GERD	Cholesterol Elevation	

Currently do you have any… *(circle yes or no, if yes, please explain)*

1. Unexplained weight loss? *Yes* *No* *If yes* ______________________________
2. Allergic or Immunocopromise? *Yes* *No* *If yes* ______________________________
3. Heart and Blood Vessel disorders (Heart attacks, High Blood Pressures)? *Yes* *No* *If yes* ______________
4. Endocrine Systems (Thyroid, Diabetes, Pituitary)? *Yes* *No* *If yes* ______________________________
5. Gastrointestinal (GERD, Stomach Ulcers)? *Yes* *No* *If yes* ______________________________
6. Neurologic (Strokes, TIA's)? *Yes* *No* *If yes* ______________________________
7. Genitourinary (*Enlarged Prostate, Bladder Leakage)? Yes* *No* *If yes* ______________________________
8. *Blood Disorders? Yes* *No* *If yes* ______________________________
9. Psychiatric (Anxiety, Depression)? *Yes* *No* *If yes* ______________________________
10. Respiratory (COPD) ? *Yes* *No* *If yes* ______________________________

Cancer *(other than skin)*: ____

Have you had any surgeries? If yes, list surgeries and approximate dates of procedure. ______________________

____

____

<u>Skin Disease</u> *Circle any of the following medical conditions that you have/had:*

Pre Cancer Actinic Keratosis	Squamous Cell	Psoriasis	Eczema
Basal Cell	Melanoma	Acne	Cold Sores

Do you wear sunscreen? *(circle one)* Yes No What SPF? __________

Do you have a family history of Melanoma? *(circle one)* Yes No If yes, who in your family *(circle below)*

Mother	Sister	Daughter	Grandmother	Aunt
Father	Brother	Son	Grandfather	Uncle

List of Medications: *(including herbals and over the counter meds)*

Medication	Dosage	Frequency	Medication	Dosage	Frequency

List of Allergies:

____

____

Are you SAFE or UNSAFE at home? *(circle one)*

How often do you exercise? Daily 2-3 times per week Not at all

Caffeine use daily? None 1 cup 2 cups 3 or more cups

What type of work do you or did you perform before retirement ?

____

Circle your answer, Yes or No

I have a defibrillator Yes No

I am pregnant or nursing Yes No

I drive during the day Yes No

I drive at night Yes No

Does anyone in your family have Diabetes? *(circle one)* *Yes* *No* If yes, who in your family *(circle below)*

Mother	Sister	Daughter	Grandmother	Aunt
Father	Brother	Son	Grandfather	Uncle

Does anyone in your immediate family have High Blood Pressure? *(circle one)* *Yes* *No* If yes, who in your family

Mother	Sister	Daughter	Grandmother	Aunt
Father	Brother	Son	Grandfather	Uncle

Does anyone in your immediate family have Psoriasis? *(circle one)* *Yes* *No*

Does anyone in your immediate family have Eczema? *(circle one)* *Yes* *No*

Does anyone in your immediate family have Non-Melanoma Skin Cancer? *(circle one)* *Yes* *No*

Immunizations *(circle yes or no)*

Have you had a Flu Shot in the past 12 months? *Yes* *No*

Have you had a Pneumococial pneumonia vaccination? *Yes* *No*

__________________ Patient Signature

__________________ Patient Name (print)

__________ Date

McDonnell Dermatology MIPS/ROS

Name:______________________________ **DOB:** ______________ **Today's Date:**____________

1. **Do you have a living will? Y N**
2. **Have you ever used any type of tobacco products? Current Former Never**
3. **ADULTS - in the past year how many times have you had more than 4 alcoholic drinks in one day? ______**

   ADOLESCENTS 13-18: In the past year how many times have you had more than 2 alcoholic drinks in one day? _____
4. **Are you up to date with your pneumonia vaccine? Y N**
5. **Have you been to your Primary Care Physician recently? Y N If yes, when?**________________________
6. **Have you been hospitalized in the last 30 days? Y N**
   If Yes, have you seen another provider as a follow up to your Hospital stay? Y N

General Medical Review of Systems

1. Do you take immunosuppressing medicines such as prednisone, biologics, or chemo? Y N
2. Has your weight unexpectedly changed by more than 10lbs in the last year? Y N
   - If Yes why? ____
3. Do you experience unexplained tiredness not related to work or activities? Y N
4. Does your skin itch? Y N
5. Do you suffer from seasonal allergies? Y N
6. Does your skin break out into hives? Y N
7. Would you consider your skin dry? Y N
8. Do you have slow wound healing? Y N
9. Do you develop large overgrown scars? Y N
10. Have you had any swelling of the lymph nodes in neck, underarms, or groin? Y N
11. Do you experience fevers, night sweats, or chills? Y N
12. Does your skin bruise and bleed easily? Y N
13. Have you had any bleeding from your nose, gums, or rectum? Y N

Office Reviewed By/Date____________________________________