# Horvath Dermatology Associates: Intake and History Form

Name: ______________________________________________ Date of Birth: _______________Today's Date: _______________

Nickname/Preferred Name: _____________________________________ Gender: ___________________________

Preferred Language: ___________________________ Race: _______________________ Ethnicity: ☐ Hispanic ☐ Non-Hispanic

☐ Home Phone: (_______) _____________________________ ☐ Work Phone: (______) _____________________________

☐ Cell Phone: (_______) _______________________________ Preferred Phone: ☐ Home ☐ Cell ☐ Work

Is it OK to leave a detailed message on your voicemail/answering machine that may include personal information? ☐ Yes ☐ No

Email Address: ___________________________________________________________________________________________

Street Address: ________________________________________________City / State: _______________________________

Zip Code: _________________ Social Security Number: _______________________ Marital Status: ________________________

Emergency Contact Name: ________________________________________ Phone: __________________________________

## Preferred Pharmacies

Local Pharmacy Name: _________________________________________________________________

Phone Number: ______________________________________

Address: ______________________________________________________________________________________________

Mail Order Pharmacy Name: _____________________________________________________________

Phone Number: ______________________________________

Address: ______________________________________________________________________________________________

## Primary Care/Referring Physician Information

Primary Care Physician: ____________________________________________________________________________________

Referring Physician if Different than Primary Care Physician: _________________________________________________________

## Insurance Information

**Primary Insurance Carrier:** _______________________________________________________________________________

Name of Policy Holder: ____________________________________ Date of Birth: ____________________ Gender: _________

ID#:______________________________________________________ Group#:_______________________________________

Patient's Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other: _______________________________________

**Secondary Insurance Carrier:** ____________________________________________________________________________

Name of Policy Holder: ____________________________________ Date of Birth: ____________________ Gender: _________

ID#:______________________________________________________ Group#:_______________________________________

Patient's Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other: _______________________________________

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## Patient Employment Information (If Applicable)

Employer's Name: ________________________________________________________________________________

Occupation: _________________________________________ Industry: _______________________________________

Please check all that apply: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Self-Employed ☐ Not Employed ☐ Student

## Disclosures to Family Members and Friends

Do you give our office permission to discuss your medical records with family members/friends? ☐ Yes ☐ No

If yes, please provide their names and phone numbers below.

Name: _______________________________________________________Relationship to Patient: ______________________

☐ Home Phone: (_______) ____________________________ ☐ Mobile Phone: (______) ____________________________

Name: _______________________________________________________Relationship to Patient: ______________________

☐ Home Phone: (_______) ____________________________ ☐ Mobile Phone: (______) ____________________________

## Parent or Legal Guardian Information – For Minors Only

Legal Guardian or Parent Name: ________________________________________________ Date of Birth: _________________

Address (If Different from Patient):__________________________________________________________________________

☐ Home Phone: (_______) ____________________________ ☐ Work Phone: (______) ____________________________

☐ Cell Phone: (_______) ______________________________ Preferred Phone: ☐ Home ☐ Cell ☐ Work

## Parent or Legal Guardian Consent – For Minors Only

I am present with my child ____________________________ today and I give my consent to see and treat my child as needed.

Signature of Parent or Guardian: _____________________________________________________

If the patient is under 18 and requires follow-up visits, I give permission for continued care in my absence. No invasive procedures will be performed without notifying the parent or guardian. _______________ Initial

If the patient is under 18 and requires follow-up, I give permission for ____________________________, (relationship to patient) _____________________________to seek medical care for my child. __________Initial

## Past Medical History

**Select any of the following medical conditions you currently have:**

- [ ] Anxiety
Arthritis
Asthma
Atrial Fibrillation
Bone Marrow Transplant
- [ ] BPH
Breast Cancer
Colon Cancer
- [ ] COPD
- [ ] Coronary Artery Disease
- [ ] Depression
Diabetes
End Stage Renal Disease
GERD
- [ ] Hearing Loss
- [ ] Hepatitis
Hypertension
- [ ] HIV / AIDS
- [ ] Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
- [ ] Radiation Treatment
- [ ] Seizures
- [ ] Stroke
- [ ] NONE
Other
_______________________________
_______________________
___________________________

## Past Surgical History

**Have you had any surgeries on the following organs?**

- [ ] Appendix (Appendectomy)
Bladder (Cystectomy)
Breast: Breast Biopsy
Breast: Lumpectomy (Right, Left, Bilateral)
- [ ] Breast: Mastectomy (Right, Left, Bilateral)

Colon (Colectomy): Colon Cancer Resection
Colon (Colectomy): Diverticulitis
Colon (Colectomy): Inflammatory Bowel Disease
Colon: Colostomy
Gallbladder (Cholecystectomy)
Heart: Coronary Artery Bypass Surgery
Heart: Heart Transplant
Heart: Mechanical Valve Replacement
Heart: PTCA

- [ ] Joint Replacement: Hip (Right, Left, Bilateral)
- [ ] Joint Replacement: Knee (Right, Left, Bilateral)
- [ ] Kidney: Kidney Biopsy

Kidney: Kidney Stone Removal

- [ ] Kidney: Kidney Transplant
- [ ] Kidney: Nephrectomy

Liver: Hepatectomy
Liver: Liver Transplant

- [ ] Live: Shunt

- [ ] Ovaries (Oophorectomy): Endometriosis

Ovaries (Oophorectomy): Ovarian Cancer
Ovaries (Oophorectomy): Ovarian Cyst

- [ ] Ovaries: Tubal Ligation
- [ ] Pancreas: Pancreatectomy
- [ ] Postate (Prostatectomy): Prostate Biopsy

Prostate (Prostatectomy: Prostate Cancer
Prostate (Prostatectomy): TURP
Rectum: APR
Rectum: Low Anterior Resection
Skin: Basal Cell Carcinoma
Skin: Melanoma
Skin: Skin Biopsy
Skin: Squamous Cell Carcinoma
Spleen (Splenectomy)
Testicles (Orchiectomy)
Uterus (Hysterectomy): Fibroids
Uterus (Hysterectomy): Uterine Cancer
Uterus (Hysterectomy): Cervical Cancer

- [ ] NONE
- [ ] Other

________________________________________
________________________________________
________________________________________

## Skin Disease History

**Have you had any of the following?**

- [ ] 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?

- Mother
- Father
- Sister
- Brother
- Daughter
- Son
- Uncle
- Aunt
- Nephew
- Niece
- Grandmother
- Grandfather
- Grandson
- Granddaughter
- Other

_______________________________________________

_______________________________________________

## Medications

List all current medications:

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

## Allergies

List all allergies and reactions if known:

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

## Social History

**Smoking Status (please choose one):**

Current every-day smoker
Current someday smoker
Former smoker
Never smoker
Unknown if ever smoked

Start Smoking:
- mm/dd/yyyy ______________________________

Quit Smoking:
- mm/dd/yyyy ______________________________

Number of Packs per Day: _________

Total Years Smoking: _____________

**Alcohol Intake (please choose one):**

None
1 or less per day
1-2 per day
3 or more per day

**Driving Status:**

- [ ] Drives in the Daytime
- [ ] Drives at Night

**How often do you exercise?**

- [ ] Unspecified
- [ ] Several times a day
- [ ] Once a day
- [ ] A few times a week
- [ ] A few times a month
- [ ] Never
- [ ] Other ______________________________________

**What is your caffeine use?**

- [ ] Unspecified
- [ ] Several times a day
- [ ] Once a day
- [ ] A few times a week
- [ ] A few times a month
- [ ] Never
- [ ] Other ______________________________________

## Family History

Please include only first-degree relatives (e.g., parent, siblings or children).

- ☐ Melanoma: ______________________________________________________________________
- ☐ Other Skin Cancer: ________________________________________________________________
- ☐ Other Cancer (Not Skin Cancer):______________________________________________________
- ☐ Eczema: _______________________________________________________________________
- ☐ Hay Fever/Allergies: _______________________________________________________________
- ☐ Psoriasis: ______________________________________________________________________
- ☐ Lupus: ________________________________________________________________________
- ☐ Other Significant Family Medical History: ____________________________________________________

## Alerts

**Please check yes or no for the following:**

| Symptom | Yes | No |
|---|---|---|
| Allergy to adhesive/tape | | |
| Allergy to lidocaine | | |
| Allergy to topical antibiotic ointments/Neosporin | | |
| Artificial heart valve | | |
| Artificial joints within past two years | | |
| Blood thinners | | |
| Defibrillator | | |
| MRSA | | |
| Pacemaker | | |
| Premedication prior to procedures | | |
| Rapid heartbeat with lidocaine | | |
| Pregnancy or planning a pregnancy | | |
| Currently breastfeeding | | |

## Review of Systems

**Please check yes or no for the following:**

| Symptom | Yes | No |
|---|---|---|
| Problems with bleeding | | |
| Problems with healing | | |
| Problems with scarring (hypertrophic or keloid) | | |
| Rash | | |
| Immunosuppression | | |
| Hay fever | | |
| Chest pain | | |
| Fever or chills | | |
| Night sweats | | |
| Unintentional weight loss | | |
| Thyroid problems | | |
| Sore throat | | |
| Blurry vision | | |
| Abdominal pain | | |
| Bloody stool | | |
| Bloody urine | | |
| Joint aches | | |
| Muscle weakness | | |
| Neck stillness | | |
| Headaches | | |
| Seizures | | |
| Cough | | |
| Shortness of breath | | |
| Wheezing | | |
| Anxiety | | |
| Depression | | |