FOX

DERMATOLOGY & AESTHETICS

Intake and History Form

Name: _____ Date of Birth: _____ Date: _____

Past Medical History

Select any of the following medical conditions you currently have:

- ☐ None
- ☐ Anxiety disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Bipolar disorder
- ☐ Blood coagulation disorder
- ☐ Bone Marrow Transplant
- ☐ BPH (Enlarged Prostate)
- ☐ Cerebrovascular accident
- ☐ Chronic obstructive lung disease
- ☐ Coronary arteriosclerosis
- ☐ Depressive disorder
- ☐ Diabetes mellitus
- ☐ Disease caused by 2019-nCoV
- ☐ Elevated blood pressure
- ☐ End-stage renal disease
- ☐ Epilepsy
- ☐ Gastroesophageal reflux disease
- ☐ Guillain-Barre syndrome
- ☐ H/O: Deep vein thrombosis
- ☐ H/O: asthma
- ☐ H/O: hay fever
- ☐ H/O: hypertension
- ☐ H/O: migraine
- ☐ H/O: thyroid disorder
- ☐ H/O: tuberculosis
- ☐ H/O: stroke
- ☐ Hepatitis B virus
- ☐ Hepatitis C virus
- ☐ Human immunodeficiency virus infection/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Inflammatory bowel disease
- ☐ Inflammatory disease of liver
- ☐ Leukemia
- ☐ Malignant lymphoma
- ☐ Malignant tumor of breast
- ☐ Malignant tumor of colon
- ☐ Malignant tumor of lung
- ☐ Malignant tumor of prostate
- ☐ Multiple sclerosis
- ☐ Parkinson's disease
- ☐ Radiation therapy treatment management
- ☐ Other:

_____

_____

_____

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Past Surgical History

Please check all that apply and list YEAR in space provided.

☐None

☐Appendix Removed _____

☐Bladder Removed _____

☐Breast: Lumpectomy (Right/Left/Both) _____

☐Breast Mastectomy (Right/Left/Both) _____

☐Breast Implants _____

☐Breast Reduction _____

☐Colon Removed (Colon Cancer Resection) _____

☐Colon Removed (Diverticulitis) _____

☐Colon Removed (IBD) _____

☐Gallbladder Removed _____

☐Heart: Biological Valve Replacement _____

☐Heart: Coronary Artery Bypass Surgery _____

☐Heart: Mechanical Valve Replacement _____

☐Heart: PTCA _____

☐Heart Transplant _____

☐H/O: tubal ligation _____

☐History of colectomy _____

☐Hysterectomy (Fibroids) _____

☐Hysterectomy (Uterine Cancer) _____

☐Kidney Biopsy _____

☐Kidney Removed (Right or Left) _____

☐Kidney Stone Removal _____

☐Kidney Transplant _____

☐Liver Transplant _____

☐Mechanical heart valve replacement _____

☐Oophorectomy _____

☐Prostate Biopsy _____

☐Prostate Removed (Prostate Cancer) _____

☐Splenectomy _____

☐Skin: Basal Cell Carcinoma _____

☐Skin: Melanoma _____

☐Skin: Squamous Cell Carcinoma _____

☐Spleen Removed _____

☐Testicles Removed _____

☐Total replacement of left hip joint _____

☐Total replacement of left knee joint _____

☐Total replacement of right hip joint _____

☐Total replacement of right knee joint _____

Other_____

_____

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Skin Disease History

- ☐ Acne
- ☐ Actinic Keratoses (Pre-Cancers)
- ☐ Basal Cell Carcinoma Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Dysplastic Nevi (Precancerous Moles)
- ☐ Eczema
- ☐ Flaking or Itching Scalp
- ☐ Hayfever/Allergies
- ☐ Malignant Melanoma Skin Cancer
- ☐ Melasma
- ☐ Poison Ivy
- ☐ Psoriasis
- ☐ Squamous Cell Carcinoma Skin Cancer
- ☐ Other

_____

_____

_____

Skin Protection

Do you wear Sunscreen? Y / N

If yes, what SPF? _____

Do you tan in a tanning salon/bed? Y / N

Do you have a FAMILY HISTORY OF SKIN CANCER? Y / N

If YES, who? _____

If YES, what kind? ☐ Melanoma ☐ Basal Cell ☐ Squamous Cell ☐ Abnormal Moles

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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

Start Smoking: mm/yyyy _____ Quit Smoking: mm/yyyy_____
Number of Packs Per Day: _____ Total Years Smoking: _____

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 _____

Do you drink alcohol? Y / N. If so, how often? Drink(s) per week _____.

Last FLU shot _____ / N/A

Have you had your Pneumonia Vaccine Y / N

Do you have a living will (advanced healthcare directive) Y / N

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Occupation and Workplace

Your occupation? _____Your Employer? _____

Place of Residence:

_____

_____

Do you currently have any of the following? Please circle all that apply.

Pacemaker

Scarring (keloid/Hypertrophic)

Muscle Weakness

Defibrillator

Immunosuppression

Neck Stiffness

Artificial Joints (within 2 yrs.)

Changing Mole

Night Sweats

Artificial Heart Valve

Rash

Seizures

Meds Required Prior to Procedure

Abdominal Pain

Shortness of Breath

Adhesive Allergy

Anxiety

Sore Throat

Allergy to Topical Antibiotics

Bloody Stool

Thyroid Problems

Blood Thinners

Bloody Urine

Unintentional Weight Loss

Pregnant or Planning Pregnancy

Blurry Vision

Wheezing

Allergy to Lidocaine

Chest Pain

Aching, Burning, Tired Legs

Rapid Heartbeat to Epinephrine

Cough

Leg Discoloration

Yeast Infections with Antibiotics

Depression

Leg Swelling or Inflammation

GI Upset with Antibiotics

Fever or Chills

Night Cramps

Breastfeeding

Headaches

Restless Leg Syndrome

Bleeding Problems

Joint Aches

Varicose Veins

Problems Healing

Other: _____