

The Dermatology Center

6410 Rockledge Drive, Suite 201, Bethesda, MD 20817 · 301-530-8300

Patient Intake Form/Medical History

Referring Physician _____

Preferred Pharmacy Name _____

Pharmacy Number _____

Name _____ Age _____ DOB _____

Please fill out sections 1-10 as completely as possible.

1.) Main reason for today's visit:	
Where is it located?	How long has it been present?
Severity/How bad is it? Please circle:	Mild Moderate Severe 1 2 3 4 5
Have you ever had a similar problem in the past and when?	
What other signs and symptoms are you experiencing? Please circle: Bleeding Growing Sore Itching Burning Changing Other (please describe):	
What have you used that makes it better/worse? (Medicines or over-the-counter products)	
2.) Please list all prescription/non-prescription medications (including topical), or vitamins are you taking <input type="checkbox"/> None <input type="checkbox"/> List:	
3.) Please list all allergies <input type="checkbox"/> None <input type="checkbox"/> List:	
4.) Family History: check the box if your blood-relative <u>family</u> members have had: <input type="checkbox"/> skin cancer (other than melanoma) <input type="checkbox"/> eczema/hay fever/asthma <input type="checkbox"/> psoriasis <input type="checkbox"/> baldness/hair loss/thinning hair <input type="checkbox"/> abnormal moles/large number of moles <input type="checkbox"/> melanoma <input type="checkbox"/> lupus/rheumatoid arthritis <input type="checkbox"/> diabetes or thyroid problems	
5.) Social History: Ethnicity/Race/Ancestry _____ Occupation _____ <input type="checkbox"/> Tobacco Use? Frequency? _____ Lifetime # of peeling sunburns _____ <input type="checkbox"/> Tanning bed use (how often)? _____ <input type="checkbox"/> Alcohol use (amt per day)? _____	
6.) Females: Are you pregnant? Y N Due Date _____ Are you trying to become pregnant? Y N Are you nursing? Y N Are your periods normal? Y N	
7) Any previous surgery (s)?	
8) Has anything else changed or happened with your health since your last visit?	

9.) Do you have any of the following?		10.) Have you had any of the following?	
Need antibiotics when having dental work	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus or lung disease (asthma, emphysema/COPD)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Recent fever, fatigue, or weight loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Thick scarring from surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No
New, changing or abnormal moles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Abnormal Bleeding/Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hair disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nail problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV/AIDS (CD4 count _____, Viral load _____)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Muscle or joint pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease, Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding problems, bleed easily	<input type="checkbox"/> Yes <input type="checkbox"/> No	Specific Skin Diseases If yes, what type? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have stomach or intestinal problems when taking medications by mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatologic disease, arthritis, lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fainting spells, seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes, thyroid, or other hormone disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty breathing, shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke, severe headaches, nerve problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Slow or rapid heart rate	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent infections, immunocompromise from organ transplant	<input type="checkbox"/> Yes <input type="checkbox"/> No
Grittiness or burning of the eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Cancer: If yes, what type? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drying, peeling, itching, flaking, or burning of skin	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other Cancer: If yes, what type? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Photo-sensitivity of skin, burn easily	<input type="checkbox"/> Yes <input type="checkbox"/> No

I understand the information above is an important part of my medical care and I have answered all of the above questions truthfully and to the best of my abilities.

Patient or Guardian sign here X _____ Date: _____

OFFICE USE ONLY: Initial History Physician Signature Grid Interval History

Patient ROS and PFS History was reviewed and unchanged, unless otherwise documented

Date Reviewed	Provider Signature	Date Reviewed	Provider Signature	Date Reviewed	Provider Signature
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____