COASTAL
DERMATOLOGY & SURGERY CENTER, P.A.

HISTORY AND INTAKE FORM

Today's Date: _____ **Referring Doctor:** _____

Patient Name: _____ **Date of Birth:** _____

Medical History (please check all that apply):

- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial joints
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Cancer (please list type): _____
- ☐ COPD/Emphysema
- ☐ Other: _____
- ☐ Surgeries (Joints, ORGAN TRANSPLANT, Other, please include dates): _____
- ☐ CABG/Stents
- ☐ Depression
- ☐ Diabetes
- ☐ GERD/Acid Reflux
- ☐ Hay Fever/Allergies
- ☐ Hearing Loss
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Kidney Disease
- ☐ Lymphoma/Leukemia
- ☐ Pacemaker/Defibrillator
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ NONE

Skin Disease History (please check all that apply):

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Cold sores
- ☐ Dry Skin/Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous cell cancer
- ☐ Tanning bed use
- ☐ NONE
- ☐ Other: _____

Do you wear sunscreen? ☐ Yes ☐ No If yes, what SPF? _____

Do you have a family history of Melanoma? ☐ Yes ☐ No If yes, which relative(s)? _____

Reason for today's visit: _____

MEDICIATIONS (please list ALL current medications, supplements, and over-the-counter medications, including dosages):

_____

_____

ALLERGIES (please list all allergies to medications):

_____

Have you received a flu shot this season? ☐ Yes ☐ No

Have you ever received the pneumonia vaccine? ☐ Yes ☐ No

Social History (please mark one for each category):

Smoking? ☐ Yes ☐ No

If former smoker: How long did you smoke? _____ When did you quit? _____

Alcohol? ☐ Yes ☐ No

Race/Ethnicity: _____

PHARMACY NAME: _____ Phone Number: _____

Address/Street: _____ City: _____ State: _____

Occupation and Hobbies: _____

Email Address: _____

Phone Number: _____ May we leave a detailed voice message? ☐ Yes ☐ No

Patient Signature: _____ **Date:** _____