COASTAL DERMATOLOGY
& SURGERY CENTER, PA
Heather A. Loesch, MD

HISTORY & INTAKE FORM

TODAY'S DATE:_____

PATIENT NAME:_____ **DATE OF BIRTH:**_____

Medical History: (please circle all that apply)

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH (Enlarged Prostrate)
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD (Emphysema)
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD (Acid reflux)
Hay Fever / Seasonal Allergies
Hearing Loss
Hepatitis
High Blood Pressure
HIV/AIDS
High Cholesterol
Hyperthyroidism (overactive)
Hypothyroidism(underactive)
Leukemia
Lung Cancer
Lymphoma
Pacemaker / Defibrillator
Prostate Cancer
Radiation Treatment
Seizures
Stroke
None

Other _____

Surgical History: (please circle all that apply and specify the year the procedure occurred)

Appendix Removed _____
Bladder Removed _____
Mastectomy (Right, Left, Bilateral)_____
Lumpectomy (Right, Left, Bilateral)_____
Breast Biopsy (Right, Left, Bilateral)_____
Breast Reduction _____
Breast Implants _____
Colectomy: Colon Cancer Resection__
Colectomy: Diverticulitis _____
Colectomy: IBD _____
Gallbladder Removed _____
Coronary Artery Bypass _____
Cardiac Stents / PTCA _____
Mechanical/Biological Valve Replacement _____
Heart Transplant _____
Joint Replacement, Knee (Right, Left, Bilateral) _____
Joint Replacement, Hip (Right, Left, Bilateral) _____
Joint Replacement Other (specify) Type_____ _____
Kidney Removed (Right, Left)_____
Kidney Stone Removal _____
Kidney Transplant: _____
Ovaries Removed: Endometriosis____
Ovaries Removed: Cyst _____
Ovaries Removed: Ovarian Cancer _____
Prostate Removed: Prostate Cancer _____
Prostate Biopsy _____
TURP (Prostrate) _____
Spleen Removed _____
Testicle(s) Removed (Right, Left, Bilateral) _____
Hysterectomy: Fibroid _____
Hysterectomy: Uterine Cancer _____

Other _____

Skin Disease History: (please circle all that apply)

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(s)? _____

Do you have family history of other skin cancer (basal/squamous)? Yes No
If yes, which relative(s)? _____

over →

PATIENT NAME:_____ **DATE OF BIRTH:**_____

Medications: (Please list all current medications, supplements and over-the-counter medications including dosages)

_____

_____

_____

_____

_____

_____

_____

_____

Allergies: (Please list all allergies)

_____

_____

_____

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Social History: (Please circle one for each category)

Cigarette Smoking:
- Never smoked
- Smokes less than daily
- Smokes daily
- Quit: former smoker –(answer below)
  - When did you quit (what year)? _____
  - How many packs per day? _____
  - How many years did you smoke? _____

Alcohol Use:
- Once a day
- A few times a week
- A few times a month
- Never

How often do you exercise?
- Once a day
- A few times a week
- A few times a month
- Never

What is your caffeine use?
- Once a day
- A few times a week
- A few times a month
- Never

Race:
- White
- Black/African American
- Asian
- American Indian or Native Alaskan
- Native Hawaiian/Pacific Islander

Ethnicity:
- Hispanic/Latino
- Non-Hispanic/Latino

Language:
- English
- Spanish
- Other:_____

Pharmacy: Name:_____

Address/Cross Streets:_____ City:_____ State:_____

Occupation and Workplace_____

Hobbies: _____

Place of Residence_____

Patient Signature: _____ Date: _____