Coastal Dermatology
& SKIN CANCER CENTER

Intake Form Page 1

Name_____ Primary Care Physician: _____
Date of Birth _____ Pharmacy: _____
Known Drug Allergies: _____
Current prescriptions AND over the counter medications:
1._____ 2._____
3._____ 4._____
5._____ 6._____

Select any of the following medical conditions that you currently have

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation (Irregular Heartbeat)
- ☐ Bone Marrow Transplantation
- ☐ BPH (Prostate)
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Other_____
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ High Blood Pressure (Hypertension)
- ☐ HIV / AIDS
- ☐ High Cholesterol (Hypercholesterolemia)
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment : Current or Past
- ☐ Seizures
- ☐ Stroke
- ☐ None

Have you had any surgeries on the following organs?

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast : Biopsy
- ☐ Breast :Lumpectomy (Right Breast)
- ☐ Breast :Lumpectomy (Left Breast)
- ☐ Breast :Mastectomy (Left Breast)
- ☐ Breast :Mastectomy (Right Breast)
- ☐ Colon (Colectomy) : Colon Cancer Resection
- ☐ Colon (Colectomy) : Diverticulitis
- ☐ Colon : Inflammatory Bowel Disease
- ☐ Colon : Colostomy
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart : Coronary Artery Bypass Surgery
- ☐ Heart : PTCA
- ☐ Heart : Mechanical Valve Replacement
- ☐ Heart : Biological Valve Replacement
- ☐ Heart : Heart Transplant
- ☐ Joint Replacement : Knee (Right)
- ☐ Joint Replacement :Knee (Left)
- ☐ Joint Replacement : Hip (Right)
- ☐ Joint Replacement : Hip (Left)
- ☐ Other_____
- ☐ None
- ☐ Kidney : Kidney Biopsy
- ☐ Kidney : Nephrectomy
- ☐ Kidney : Kidney Stone Removal
- ☐ Kidney : Kidney Transplant
- ☐ Liver : Transplant
- ☐ Liver : Shunt
- ☐ Ovaries (Oophorectomy) : Endometriosis
- ☐ Ovaries (Oophorectomy) : Ovarian Cysts
- ☐ Ovaries (Oophorectomy) : Cancer
- ☐ Ovaries: Tubal Ligation
- ☐ Prostate (Prostatectomy) : Cancer
- ☐ Prostate (Prostatectomy) : Biopsy
- ☐ Prostate (Prostatectomy) : TURP
- ☐ Skin : Skin Biopsy
- ☐ Skin : Basal Cell Carcinoma
- ☐ Skin : Squamous Cell Carcinoma
- ☐ Skin : Melanoma
- ☐ Spleen (Splenectomy)
- ☐ Testicles (Orchiectomy)
- ☐ Uterus (Hysterectomy) : Fibroids
- ☐ Uterus (Hysterectomy) : Uterine Cancer
- ☐ Uterus (Hysterectomy) : Cervical Cancer
- ☐ Uterus Hysterectomy: Partial or Total

CONTINUED ON BACK

Intake Form Page 2

Have you had any of the following skin conditions?

- ☐ Acne
- ☐ Actinic Keratoses (Pre Cancers)
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Other_____
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous cell skin cancer
- ☐ None

Do you wear Sunscreen?
☐ Yes ☐ No If yes, what SPF? _____
Do you tan in a tanning salon?
☐ Yes ☐ No

Family History
Do you have a family history of **Melanoma**?
☐ Yes ☐ No
If yes, which relative?

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

Social History Details
Do you currently smoke cigarettes? ☐ Yes ☐ No
Have you ever smoked cigarettes? ☐ Yes ☐ No

- ☐ Alcohol: none
- ☐ Alcohol: less than 1 drink per day
- ☐ Alcohol: 1-2 drinks per day
- ☐ Alcohol: 3 or more drinks per day
- ☐ Patient feels safe at home
- ☐ Patient feels unsafe at home

Do you currently have any of the following?

- ☐ Allergy to Epinephrine
- ☐ Allergy to adhesive
- ☐ Allergy to lidocaine
- ☐ Allergy to latex
- ☐ Allergy to topical antibiotic ointments
- ☐ Artificial heart valve
- ☐ Artificial joints within past two years
- ☐ Blood thinners
- ☐ Defibrillator
- ☐ Pacemaker
- ☐ Premedication prior to procedures
- ☐ Rapid heartbeat with epinephrine
- ☐ Pregnancy or planning a pregnancy

Occupation/Hobbies:_____
Email Address: _____