Menlo Dermatology Medical Group & Laser Center, Inc.

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PATIENT INTAKE & HISTORY

Patient Name:_____ **Date Of Birth:** _____

History & Background Information

Language: ☐ English ☐ Spanish ☐ Chinese ☐ Japanese ☐ French ☐ Decline to state ☐ Other _____

Race: ☐ White ☐ Asian ☐ Amer. Indian/Alaska Native ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ Other _____

Ethnic Group: ☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Unknown ☐ Decline to state

Past Medical History: (Select any of the following medical conditions that you currently have)

☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Atrial Fib
☐ Bone Marrow Transplant
☐ BPH
☐ Breast Cancer
☐ Colon Cancer
☐ COPD
☐ Coronary Artery Disease
☐ Depression
☐ Diabetes
☐ End Stage Renal Disease
☐ GERD
☐ Other_____
☐ Hearing Loss
☐ Hepatitis
☐ Hypertension
☐ HIV/AIDS
☐ Hypercholesterolemia
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Leukemia
☐ Lung Cancer
☐ Lymphoma
☐ Prostate Cancer
☐ Radiation Treatment
☐ Seizures
☐ Stroke
☐ **None**

Past Surgical History: Have you had any surgeries on the following organs? (please specify where indicated)

☐ Appendix
☐ Bladder
☐ Breast – Lumpectomy (Rt, Lft, Bilateral)
☐ Breast – Mastectomy (Rt, Lft, Bilateral)
☐ Colon – Diverticulitis
☐ Colon Cancer Resection
☐ Colon – IBD
☐ Colostomy
☐ Gallbladder
☐ Heart Bypass
☐ Heart Valve Replacement (Mechanical, Biological)
☐ Heart Transplant
☐ Heart – Angioplasty (PTCA)
☐ Hip Replacement (Rt, Lft, Both)
☐ Knee Replacement (Rt, Lft, Both)
☐ Kidney Transplant
☐ Kidney Removal
☐ Liver Removal
☐ Liver Transplant
☐ Liver Shunt
☐ Ovarian Cancer
☐ Ovarian Cyst
☐ Ovaries-Tubal Ligation
☐ Ovaries-Endometriosis
☐ Other _____
☐ Pancreatectomy
☐ Prostate Cancer
☐ Prostatectomy (TURP)
☐ Rectal Cancer (APR, Low Anterior)
☐ Splenectomy
☐ Testicles (Orchiectomy)
☐ Uterine Cancer (Hysterectomy)
☐ Uterine Fibroids
☐ Uterus - Cervical Cancer
☐ **None**

Skin Disease History: Have you had any of the following skin conditions? (check all that apply)

☐ Acne
☐ Actinic Keratosis
☐ Asthma
☐ Basal Cell Cancer
☐ Blistering Sunburns
☐ Dry Skin
☐ Eczema
☐ Flaking or Itchy Scalp
☐ Hay Fever/Allergies
☐ Melanoma
☐ Poison Ivy
☐ Precancerous Moles
☐ Psoriasis
☐ Squamous Cell Cancer
☐ Other:_____
☐ **None**

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? ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Son ☐ Daughter

Medications: (please list all current medications) ☐ **NONE**

_____

_____

_____

_____

_____

_____

_____

Preferred Pharmacy (please specify location): _____ City: _____

Pharmacy Phone #: _____

Allergies (please list**)**: ☐ **NONE**

_____

_____

Describe Reaction:_____

_____

_____

Alerts: (please check all that apply):

☐ Latex allergy ☐ Adhesive allergy ☐ Lidocaine allergy ☐ Topical antibiotics allergy
☐ Artificial Heart Valve ☐ Artificial Joint Replacement ☐ Blood Thinners ☐ Defibrillator
☐ MRSA ☐ Pacemaker ☐ Require premedication prior to procedures
☐ Rapid heartbeat w/epinephrine ☐ Pregnant/Planning Pregnancy ☐ **NONE**

Social History: Cigarette Smoking: ☐ Current smoker ☐ Smoke occasionally ☐ Former smoker ☐ Never smoked

Alcohol Use: ☐ None ☐ Less than 1 per day ☐ 1-2 per day ☐ 3 or more per day

Family History:

Do you have a family history of a skin disease? ☐ Yes ☐ No

If yes what type? _____

If yes, which relative? ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Son ☐ Daughter

Do you have a family history of other non-melanoma skin cancers? (BCC, SCC) ☐ Yes ☐ No

If yes, what type?_____

If yes, which relative? ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Son ☐ Daughter