Kentucky Dermatology & Cosmetic Specialists

History & Intake Form

First Name: _____ MI: ____ Last: _____ Date: _____
Occupation: _____ Employer: _____
Reason for Visit: _____

Medications –List all CURRENT medications include strength and dosage:

_____ _____
_____ _____
_____ _____
_____ _____

_____by initialing, I am giving Kentucky Dermatology permission to reconcile my prescription list with information SureScripts regarding; medications, strength, dosages, etc.

Allergies – List all allergies and reactions if known

_____ _____
_____ _____
_____ _____

Medical History-Select any of the following medical conditions you currently have or have had:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ PBH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ NONE
- ☐ Other
  _____
  _____
  _____

Past Surgical History – Have you had any surgeries on the following organs? ☐ **NONE**

- ☐ Appendix
- ☐ Bladder
- ☐ Breast: Breast Biopsy
- ☐ Breast: Lumpectomy (RT, Lt, Both)
- ☐ Breast: Mastectomy (RT, Lt, Both)
- ☐ Colon (Type):
- ☐ Gall Bladder
- ☐ Heart: Bypass Surgery
- ☐ Heart: Heart Transplant
- ☐ Heart: Valve Replaced
- ☐ Joint Replace: Hip (RT, Lt, Both)
- ☐ Joint Replace: Knee (RT, LT, Both)
- ☐ Other _____
- ☐ Kidney Stone Removal
- ☐ Kidney: Kidney Transplant
- ☐ Kidney: Nephrectomy
- ☐ Liver: liver Transplant
- ☐ Liver: Other
- ☐ Ovaries: Ovarian Cancer
- ☐ Ovaries: Ovarian Cyst
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate: Biopsy
- ☐ Prostate: Prostate Cancer
- ☐ Prostate (Prostatectomy: TURP
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Spleen (Splenectomy)
- ☐ Testicles (Orchiectomy)
- ☐ Uterus (Hysterectomy): Fibroids
- ☐ Uterine Cancer (Hysterectomy)
- ☐ Cervical Cancer (Hysterectomy)
- ☐ Rectum: APR
- ☐ Kidney: Biopsy
- ☐ NONE

Skin Disease history _Have you had any of the following?

☐ Acne	☐ Dry Skin	☐ Poison Ivy	☐ Stroke
☐ Actinic Keratosis	☐ Eczema	☐ Hyperthyroid	☐ NONE
☐ Asthma	☐ Flaking or Itchy Scalp	☐ Hypothyroidism	☐ Other
☐ Basal Cell Skin Cancer	☐ Hay Fever / Allergies	☐ Leukemia	_____
☐ Blistering Sunburns	☐ Melanoma	☐ Lung Cancer	_____

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 ☐ Brother ☐ Sister ☐ Daughter ☐ Son ☐ Uncle ☐ Aunt ☐ Other _____

Smoking Status: ☐ Current Every Day ☐ Current occasional ☐ Former smoker ☐ Never smoker

Alcohol Intake: ☐ None ☐ 1 or less per day ☐ 1-2 per day ☐ 3 or more per day

Family History – Please include relationship of person to you

☐ Psoriasis _____	☐ Asthma _____	☐ other diseases related to your visit:
☐ Skin Cancer_____	☐ Diabetes _____	_____
☐ Eczema _____	☐ Arthritis_____	_____
☐ Hay Fever_____	☐ Cancer _____	_____

Height: _____ft. _____inches **Weight _____ lbs.**

Review of Systems – Please check yes or no for the following:

Anemia or problems with Bleeding	☐ Yes	☐ No	History of Hepatitis	☐ Yes	☐ No
Problems with Scarring (hypertrophic or keloid)	☐ Yes	☐ No	History of Arthritis	☐ Yes	☐ No
Eczema / Psoriasis	☐ Yes	☐ No	Headaches or Seizures	☐ Yes	☐ No
Immunosuppression	☐ Yes	☐ No	Asthma/ Lung Disease	☐ Yes	☐ No
Allergies / Hay Fever	☐ Yes	☐ No	Wheezing	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Anxiety / Depression	☐ Yes	☐ No
Flu like Symptoms	☐ Yes	☐ No	Diabetic	☐ Yes	☐ No
Thyroid Problems	☐ Yes	☐ No	Other: _____	☐ Yes	☐ No

Alerts:

Allergy to Latex	☐ Yes	☐ No	Skin Infections	☐ Yes	☐ No
Allergy to ANY Medications	☐ Yes	☐ No	Do you require premedication before procedures	☐ Yes	☐ No
Blood Thinners	☐ Yes	☐ No	Pregnant or planning to become pregnant	☐ Yes	☐ No

_____	_____	_____	_____
Patient or Guardian Signature	**Date**	**Staff Initials**	**Provider Initials**