



# CASCADE DERMATOLOGY

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Today's Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## INTAKE & HISTORY FORM

Name \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
LAST FIRST M.I.

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Social Security # \_\_\_\_\_ Sex:  Male  Female

Mailing Address \_\_\_\_\_  
CITY STATE ZIP

Physical Address (if different than above) \_\_\_\_\_  
CITY STATE ZIP

Email Address: \_\_\_\_\_ Would you like access to your online portal?  Yes  No

Home Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_ Preferred:  Home  Cell

In an emergency who should be notified? \_\_\_\_\_ Phone Number: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed  Separated  Partnered

Driver's License Number & State: \_\_\_\_\_ Do you have an advanced directive?  Yes  No

Occupation (former or current) \_\_\_\_\_

Are you retired?  Yes  No

### PARENT, SPOUSE OR RESPONSIBLE PARTY (If Student, parent's address)

Name \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_  
LAST FIRST M.I.

Address \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_  
STREET / PO BOX

(if different than above)

\_\_\_\_\_  
CITY STATE ZIP Sex:  Male  Female

### DO WE HAVE YOUR PERMISSION TO: (Please check all that apply)

Leave a message: Home phone  Yes  No Cell phone  Yes  No

Discuss your medical condition with any member of your household? .....  Yes  No

If yes, name: \_\_\_\_\_ Relationship: \_\_\_\_\_

If yes, name: \_\_\_\_\_ Relationship: \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_

Preferred Pharmacy Name & Location: \_\_\_\_\_

**Past Medical History:** (please check all that apply)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Anxiety                | <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> MRSA                |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> GERD                    | <input type="checkbox"/> Organ Transplant    |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Hearing Loss            | <input type="checkbox"/> Pacemaker           |
| <input type="checkbox"/> Atrial Fibrillation    | <input type="checkbox"/> Heart Failure           | <input type="checkbox"/> Prostate Cancer     |
| <input type="checkbox"/> Autoimmune Disease     | <input type="checkbox"/> Hepatitis: A/B/C?       | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Bone Marrow Transplant | <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Seizures            |
| <input type="checkbox"/> Breast Cancer          | <input type="checkbox"/> High Cholesterol        | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Colon Cancer           | <input type="checkbox"/> HIV/AIDS                | <input type="checkbox"/> Thyroid Problems    |
| <input type="checkbox"/> COPD                   | <input type="checkbox"/> Leukemia                | <input type="checkbox"/> Ulcer               |
| <input type="checkbox"/> Depression             | <input type="checkbox"/> Lung Cancer             | <input type="checkbox"/> None                |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Lymphoma                |  |

**Past Surgical History:** (please check all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> Mastectomy (Right, Left, Both)              | <input type="checkbox"/> Joint Replacement, Hip (Right, Left, Both) |
| <input type="checkbox"/> Lumpectomy (Right, Left, Both)              | <input type="checkbox"/> Kidney Transplant                          |
| <input type="checkbox"/> Coronary Artery Bypass                      | <input type="checkbox"/> Prostate Removed: Prostate Cancer          |
| <input type="checkbox"/> Mechanical Valve Replacement                | <input type="checkbox"/> Prostate Biopsy                            |
| <input type="checkbox"/> Biological Valve Replacement                | <input type="checkbox"/> NONE                                       |
| <input type="checkbox"/> Joint Replacement, Knee (Right, Left, Both) |   |

Other: \_\_\_\_\_

**Skin Disease History:** (please check all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> Acne  | <input type="checkbox"/> Flaking or Itchy Scalp |
| <input type="checkbox"/> Actinic Keratosis   | <input type="checkbox"/> Hay Fever/Allergies    |
| <input type="checkbox"/> Blistering Sunburns   | <input type="checkbox"/> Poison Oak/Ivy         |
| <input type="checkbox"/> Dry Skin  | <input type="checkbox"/> Precancerous Moles     |
| <input type="checkbox"/> Itchy Skin  | <input type="checkbox"/> Psoriasis              |
| <input type="checkbox"/> Eczema or Rash  | <input type="checkbox"/> Warts                  |
| <input type="checkbox"/> Skin Cancer (circle all that apply) (squamous cell/basal cell/melanoma/other) | <input type="checkbox"/> MOH's Surgery          |
|  | <input type="checkbox"/> NONE                   |

Other: \_\_\_\_\_

Do you wear sunscreen? If yes, what SPF? \_\_\_\_\_ Sunscreen use:  Daily  Sometimes  None

Do you tan in a tanning salon?  Yes  No

**Social History:** (please check all that apply)

**Cigarette Smoking:**

- Current Every Day Smoker
- Occasional Smoker
- Former Smoker
- Never Smoked

**Alcohol Use:**

- None
- Less than 1 drink per day
- 1-2 drinks per day
- 3 or more drinks per day

**Women:** are you pregnant? Yes No      Are you trying to get pregnant? Yes No

**Family History:** (PLEASE CIRCLE FOR: M=mother, F=father, B=brother, S=sister, D=daughter, SN=son)

Cancer (type?): \_\_\_\_\_  
M F B S D SN

Psoriasis: M F B S D SN

Skin Cancer: M F B S D SN

Cancer (type?): \_\_\_\_\_  
M F B S D SN

Eczema: M F B S D SN

Melanoma: M F B S D SN

Diabetes: M F B S D SN

Asthma: M F B S D SN

Other: \_\_\_\_\_  
M F B S D SN

Heart Disease: M F B S D SN

Hay Fever: M F B S D SN

\_\_\_\_\_  
M F B S D SN

**Medications:**

Are you currently taking any blood thinners?  Yes  No ---If yes, medication name? \_\_\_\_\_

Do you have any allergies to medications?  Yes  No

If yes, what medication(s)? \_\_\_\_\_

Please list medications you are currently taking or attach a list:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had a shingles (herpes zoster) vaccine?  Yes  No

Have you ever used a topical chemotherapy cream? (Efudex, fluorouracil, Picato, etc)  Yes  No

What are the reasons for today's visit? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Is there anything else you would like to tell us? \_\_\_\_\_

\_\_\_\_\_

**Do you have problems with the following?** (please check all that apply)

- problems with healing
- problems with scarring

- band-aid or tape allergy
- problems with bleeding

- thyroid problems
- antibiotic ointment allergy
- problems w/local anesthetic

*By signing below, I agree that the information on this form is accurate to the best of my knowledge:*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_