CASCADE DERMATOLOGY

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Reset Form

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)*

_____ Sex: ◯ Male ◯ Female
CITY STATE ZIP

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)

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

Past Surgical History: (please check all that apply)

- ☐ Mastectomy (Right, Left, Both)
- ☐ Lumpectomy (Right, Left, Both)
- ☐ Coronary Artery Bypass
- ☐ Mechanical Valve Replacement
- ☐ Biological Valve Replacement
- ☐ Joint Replacement, Knee (Right, Left, Both)
- ☐ Joint Replacement, Hip (Right, Left, Both)
- ☐ Kidney Transplant
- ☐ Prostate Removed: Prostate Cancer
- ☐ Prostate Biopsy
- ☐ NONE

Other: _____

Skin Disease History: (please check all that apply)

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Itchy Skin
- ☐ Eczema or Rash
- ☐ Skin Cancer (circle all that apply) (squamous cell/basal cell/melanoma/other)
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Poison Oak/Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Warts
- ☐ MOH's Surgery
- ☐ 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*

Cancer (type?): _____ *M F B S D SN*

Diabetes: *M F B S D SN*

Heart Disease: *M F B S D SN*

Psoriasis: *M F B S D SN*

Eczema: *M F B S D SN*

Asthma: *M F B S D SN*

Hay Fever: *M F B S D SN*

Skin Cancer: *M F B S D SN*

Melanoma: *M F B S D SN*

Other: _____ *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: _____

Print Form