MIDWEST CENTER FOR DERMATOLOGY & COSMETIC SURGERY
a DOCS affiliate

Spa 43 COSMETIC & LASER CENTER
a DOCS affiliate

NAME: _____

History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation (irreg heart beat)
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
High Blood pressure
HIV/AIDS
High Cholesterol
Thyroid Problems hyper/hypo
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke

NONE

Other _____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Breast: Mastectomy (Right, Left, Bilateral)
Breast: Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed (cholecystectomy)
Coronary Artery Bypass
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)

Joint Replacement within last 2 years
Kidney Biopsy (Nephrectomy)
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Liver: Shunt
Liver: Transplant
Liver: Hepatectomy
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Ovaries: Tubal ligation
Pancreas removed
Prostate Removed: Prostate Cancer
Prostate Biopsy
Rectum: Lower resection
TURP (Prostate Removal)
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer

NONE

Other _____

NAME: _____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer

NONE

Other _____

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(s)? _____

Medications: (Please enter all current medications)

_____
_____
_____

Allergies: (Please enter all allergies)

_____
_____
_____

Family History: (Only first degree relatives)

_____
_____
_____

Social History: (Please circle all that apply)

Cigarette Smoking:
Current ever day smoker
Current someday smoker
Former smoker
Never smoker
Cigar smoker
Heavy tobacco smoker
Light tobacco smoker

Alcohol Use:
EtOH- None
EtOH- less than 1 drink per day
EtOH -1-2 drinks per day
EtOH -3 or more drinks per day

Other_____

Preferred Language: _____Race:_____Ethnic Group:_____

Preferred pharmacy Name: _____Phone #_____City or Zip Code_____

NAME: _____

Review of Systems: Are you currently experiencing any of the following?
(Please check yes or no for the following)

Symptom	Yes	No
Problems with bleeding		
Problems with healing		
Problems with scarring		
Rash		
Immunosuppression		
Hay fever		
Shortness of breath		
Joint aches		
Fever or chills		
Night sweats		
Nausea		
Vomiting		
Abdominal pain		
Hair loss		
Headaches		
Eye pain		
Blurry vision		
Bloody urine		
Bloody stool		
Depression		
Unintentional weight loss		
Thyroid problems		
Sore throat		
Muscle weakness		
Chest pain		
Neck stiffness		
Seizures		
Cough		
Wheezing		
Anxiety		

Other Symptoms: _____