FINDLEY DERMATOLOGY

History and Intake Questionnaire

Please circle yes/no and provide all relevant answers and requested details.If you brought a list of your current medications, please hand this in along with the questionnaire.

Today's Date: _____ Name: _____

Date of Birth: _____ Sex: _____

Mailing Address: _____

_____

Email Address: _____

Permission to email? Yes / No

Best Contact phone #: _____ Okay to leave a voicemail? Yes / No

Who do you prefer we contact to schedule appointments?

Name: _____ Phone #: _____

Relationship: _____

Occupation: _____ Primary Care Doctor: _____

How did you hear about our office? _____

Preferred language? _____ Race: _____

Ethnicity: _____

Preferred pharmacy (please include name, phone # and address):

_____

_____

_____

Insurance Policy Holder Information

Name of Policy Holder: _____

Policy Holder's Date of Birth:_____

Policy Holder Address (if different from above):

_____

_____

Do you have an advanced care directive? Yes / No

If yes, please specify: _____

Who is your durable power of attorney? _____

Do you have specific areas of concern today? Please specify:

_____

Past Medical History

☐ High blood pressure	☐ Heart Attack	☐ High Cholesterol	☐ Diabetes
☐ Atrial Fibrillation	☐ Kidney disease	☐ Asthma	☐ COPD
☐ Anxiety or Depression	☐ Arthritis	☐ Stroke	☐ HIV/AIDS
☐ Thyroid Disorders	☐ Hearing loss		

Cancer (type): _____

Organ Transplantation (liver, kidney etc): ____ _____

Other: _____

History of radiation treatment? Yes / No

Please describe: _____

Do you have a pacemaker? Yes / No Defibrillator? Yes / No

Do you have a history of MRSA? Yes / No

Do you require antibiotics prior to surgical procedures? Yes / No

Do you have problems with bleeding? Yes / No

If yes, please describe: _____

Do you have a history of abnormal scarring (keloids)? Yes / No

If yes, please describe: _____

Are you pregnant or trying to become pregnant? Yes / No Currently breastfeeding? Yes / No

Prior Surgical History

History of joint replacement: _____

Other surgical history:

_____

_____

Past Dermatologic History

Personal history of skin cancer: ☐ Basal cell ☐ Squamous cell ☐ Melanoma ☐ Merkel Cell

Other_____

Please specify body location, date and treatment: _____

Family History of Skin cancers (first degree relatives only): Yes / No

Family history of melanoma? Yes / No

Please specify: _____

Other skin conditions: ☐ Acne ☐ Eczema ☐ Psoriasis ☐ Actinic keratoses (pre-cancers)
☐ Atypical moles ☐ Dry Skin ☐ Warts ☐ Blistering sunburns

History of Accutane use: Yes / No

(if yes, please provide date(s) of treatment) _____

Do you currently tan at a tanning salon? Yes / No Prior tanning bed use: Yes / No

Do you wear sunscreen? Yes / No If yes, what SPF? _____

Do you tan or burn with excess sun exposure?_____

Current Medications	Strength	Dose	Frequency

Do you take any of the following?

☐ Aspirin ☐ Eliquis ☐ Pradaxa ☐ Xarelto ☐ Warfarin ☐ Plavix

Allergies

_____

_____

Are you allergic to any of the following? ☐ Adhesive ☐ Lidocaine ☐ Topical ☐ Antibiotics ☐ Latex

Do you develop a rapid heartbeat with epinephrine? Yes / No

Review of Systems

Please circle all that apply.

Rash	Hay Fever	Chest pain	Sore throat	Fever or chills
Blurry vision	Abdominal pain	Headaches	Migraines	Joint Aches
Bloody stool	Bloody urine	Thyroid problems	Unintentional weight loss	
Immunosuppression	Other symptoms: _____			

Social History

Do you smoke and frequency? Yes / No _____ Cigars? Yes / No

Do you consume alcohol and frequency? Yes / No _____

Did you receive the following vaccines?

Flu: Yes / No Pneumonia: Yes / No Shingles? Yes / No Covid: Yes / No