HOUCKDERMATOLOGY

Last Name: _____ **First Name:** _____

DOB _____ **Gender:** M or F

Responsible Party: **Last Name:** _____ **First Name:** _____

DOB: _____ **Gender:** M or F

Permanent Billing Address: _____

City: _____ **State:** _____ **ZIP:** _____

_____

Alternate Address: _____

City: _____ **State:** _____ **ZIP:** _____

_____

Please provide TWO phone numbers if possible

Cell: _____ **Other:** _____

E-Mail: _____ **Would you like to be added to our E-Mail List?** Y or N

Preferred Language: English Spanish Other:_____

Race: American Indian/Alaska Native Asian Black or African American

Native Hawaiian/Pacific Islander White Other Decline to specify

Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown Decline to specify

Local Primary Care Physician: _____

How did you hear about our office? _____

Have you had the Pneumonia vaccination in the last 3-5 years? Yes or No

Patient Intake Form

Name: _____ **DOB:** _____

Preferred Pharmacy

Pharmacy Name:
City & Intersection:

Past Medical History (Please circle all that apply)

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

Past Surgical History

NONE
Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Colostomy
Gallbladder Removed
Heart: Coronary Artery Bypass
Heart: PTCA
Heart: Mechanical Valve Replacement
Heart: Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Kidney Biopsy (Nephrectomy)
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Liver Shunt
Liver Transplant
Liver Removal
Ovaries Removed: Endometriosis
Ovaries Removed; Cyst
Ovaries Removed: Ovarian Cancer
Ovaries: Tubal Ligation
Pancreas Removed
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP (Prostate Removal)
Rectum Removed
Skin Cancer Surgery (Basal, Squamous, Melanoma)
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
Hysterectomy: Cervical Cancer
OTHER _____

Skin Disease History (Please circle all that apply)

NONE

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

Medications

NONE

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Allergies to Medications

NONE

_____ _____

_____ _____

_____ _____

Social History

Smoking:	Current Smoker	Former Smoker	Never Smoked		
Alcohol:	None	Less than 1 drink/day	1-2 drinks/day	3+ drinks/day	

Family History (please circle all that apply – 1st degree relatives)

Malignant Neoplasm	YES	NO
Neoplasm of Skin	YES	NO
Skin Disease	YES	NO

Review of Systems

Problems with bleeding	YES	NO	Allergy to any antibiotic medications			YES	NO
Problems with healing	YES	NO	Defibrillator			YES	NO
Problems with scarring	YES	NO	Pacemaker			YES	NO
Blood thinners	YES	NO	Artificial heart valve		YES	NO	
Allergy to adhesives	YES	NO	Artificial joint replacement		YES	NO	
Allergy to lidocaine	YES	NO	Antibiotics prior to surgical procedure	YES	NO		
Allergy to iodine	YES	NO	Rapid heartbeat with epinephrine			YES	NO
			Pregnant, trying or breastfeeding			YES	NO

Aesthetic Intake Form

Name _____ **DOB** _____

Skin History

1. Which of the following best describes your skin type?
   (please check one)

_____	I creamy complexion	always burns easily, never tans
_____	II light complexion	always burns, tans slightly
_____	III light/matte complexion	burns moderately, tans gradually
_____	IV matte complexion	seldom burns, tans well
_____	V brown complexion	rarely burns, deep tan
_____	VI black complexion	never burns, deeply pigmented

2. Do you have any skin care problems or concerns?
   _____

3. Have you used any of the following in the past 3 months?
   _____ Retinoids _____ Accutane _____ Alpha Hydroxy Acid

4. Have you ever had a laser treatment, chemical peel, or microdermabrasion? Yes No
   If yes, when? _____

5. Do you have any allergies or sensitivities?
   _____

6. Have you ever had Botox, Restylane, Juvederm, collagen, or any other injections? Yes No
   If yes, when? _____

7. Do you have any problems with scarring? _____

Skin

_____ breakouts/acne	_____ blackheads/whiteheads	_____ excessive oil
_____ rosacea	_____ dryness	_____ broken capillaries
_____ sun spots/brown spots	_____ uneven skin tone	_____ sun damage
_____ wrinkles/fine lines	_____ dehydrated	_____ large pores
_____ redness		

Eyes

_____ dehydrated	_____ wrinkles/fine lines	_____ puffiness
_____ dark circles	_____ lost of elasticity	

Mouth

_____ wrinkles/fine lines	_____ dehydrated	_____ cracked/chapped
_____ nasolabial folds		

What skin care products are you currently using?
(Please list brand)

cleanser _____ toner _____

moisturizer _____ serum _____

sunscreen _____ exfoliator _____

mask _____ body lotion _____