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
Actinic Keratoses (pre cancers)
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

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
Problems with healing YES NO
Problems with scarring YES NO
Blood thinners YES NO
Allergy to adhesives YES NO
Allergy to lidocaine YES NO
Allergy to iodine YES NO

Allergy to any antibiotic medications YES NO
Defibrillator YES NO
Pacemaker YES NO
Artificial heart valve YES NO
Artificial joint replacement YES NO
Antibiotics prior to surgical procedure 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
_____