North Idaho DERMATOLOGY

2288 N. Merritt Creek Loop
Coeur d'Alene, ID 83814

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niderm.com

Name_____
(Last) (First) (Middle Initial)

Birthdate:_____

Preferred Language: (circle one) English Spanish Unspecified Other_____

Ethnicity: (circle one) Hispanic or Latino Non Hispanic or Latino Unknown Unspecified

Race: (circle one) White American Indian or Native Alaskan Asian Black or African American
Native Hawaiian or other Pacific Islander Other Race Unspecified

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Preferred Pharmacy (Store name and Location) _____

Referring Doctor's name/clinic_____

I authorize North Idaho Dermatology to discuss my medical/financial information with the following people:

Name:_____

Phone:_____ Relationship:_____

Name:_____

Phone:_____ Relationship:_____

History and Intake Form

Current problems with (Please circle all that apply):

Problems with bleeding	Night Sweats	Muscle Weakness
Problems with healing	Unintentional weight loss	Neck Stiffness
Problems with scarring	Thyroid Problems	Headaches
Rash	Sore Throat	Seizures
Immunosuppression	Blurry vision	Cough
Hay Fever	Abdominal pain	Shortness of breath
Chest Pain	Bloody stool/ Bloody urine	Wheezing
Fever or Chills	Joint aches	Anxiety/ Depression

Alerts (Please circle all that apply):

Allergy to Latex	Allergy to Lidocaine	Allergy to Topical antibiotic ointment
Artificial or damaged heart valve	Allergy to Adhesive	Blood thinners
Defibrillator	Pacemaker	Premedication prior to procedures
Rapid heartbeat with epinephrine	Pregnant or planning a pregnancy	Artificial joints within past two years

Past Medical History: (Please circle all that apply): **NONE**

Anxiety	Coronary Artery Disease	Hyperthyroidism
Arthritis	Depression	Hypothyroidism
Artificial Joints	Diabetes	Leukemia
Asthma	End Stage Renal Disease	Lung Cancer
Atrial fibrillation	GERD	Lymphoma
BPH	Hearing Loss	Pacemaker
Bone Marrow Transplantation	Hepatitis	Prostate Cancer
Breast Cancer	Hypertension	Radiation Treatment
Colon Cancer	HIV/AIDS	Seizures
COPD	Hypercholesterolemia	Stroke
		Valve Replacement

Other Medical History_____

Past Surgical History: (Please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Heart: Coronary Artery Bypass
Heart: PTCA
Heart: Mechanical Valve Replacement
Heart: Biological Valve Replacement
Heart: Heart Transplant
Joint Replacement, Knee- (Right, Left, Bilateral)
Joint Replacement, Hip- (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed
Ovaries: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
Prostate: TURP
Skin Biopsy
Skin: Basal Cell Cancer Surgery
Skin: Squamous Cell Cancer Surgery
Skin: Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
None

Other_____

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)? _____
Any other family skin cancer history? _____

Medications: (Please list names of all current medications)

_____

_____

_____

Allergies: (Please list all allergies)

_____

History of Smoking (Please circle): Never smoked Former smoker Smokes less than daily Smokes daily

Patient or Guardian Signature_____

Date_____