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Patient Intake Form

Name: _____
(Last) (First) (Middle Initial)

Birthdate: _____ Email: _____ Phone: _____

Ethnicity (Circle one): Hispanic or Latino Non-Hispanic or Latino Unknown/Unspecified

Preferred Language (Circle one): English Spanish Unspecified Other _____

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

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

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Preferred Pharmacy (Name & Location): _____

Referring Doctor's Name/Clinic: _____

Medications (please list names of all current medications):

Allergies (please list all allergies):

Current problems with (circle all that apply):

- | | | | |
|------------------------|---------------------------|--------------------|---------------------|
| Problems with bleeding | Fever or Chills | Bloody Stool/Urine | Shortness of Breath |
| Problems with healing | Night Sweats | Joint Aches | Wheezing |
| Problems with scarring | Unintentional Weight Loss | Muscle Weakness | Anxiety/Depression |
| Rash | Thyroid Problems | Neck Stiffness | |
| Immunosuppression | Sore Throat | Headaches | |
| Hay Fever | Blurry Vision | Seizures | |
| Chest Pain | Abdominal Pain | Cough | |

Past Medical History (circle all that apply):

- | | | |
|---------------------------|-------------------------------|---------------------|
| None | Diseased caused by COVID-19 | Hypothyroidism |
| Anxiety | Elevated Blood Pressure | Leukemia |
| Arthritis | End Stage Renal Disease | Lung Cancer |
| Asthma | Epilepsy | Lymphoma |
| Atrial Fibrillation | GERO | Pacemaker |
| BPH | H/O: Hypertension | Prostate Cancer |
| Cereborvascular (Stroke) | Hearing Loss | Radiation Treatment |
| COPD | HIV Infection | Seizures |
| Coronary Arterlosclerosis | Hypercholesterolemia | Valve Replacement |
| Depressive Disorder | Hyperthyroidism | |
| Diabetes | Inflammatory Disease of Liver | |

MORE ON BACK

Alerts (circle all that apply):

- | | |
|--|---|
| Allergy to Latex | Rapid Heartbeat with Epinephrine |
| Allergy to Lidocaine | Pacemaker |
| Allergy to Adhesive | Blood Thinners |
| Allergy to Topical antibiotic ointment | Premedication prior to procedures |
| Artificial or Damaged Heart Valve | Artificial Joints within the past two years |
| Defibrillator | Pregnant or planning a pregnancy |

Skin Disease History (circle all that apply):

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

Past Surgical History (circle all that apply):

- | | | |
|--|---|---|
| Appendix Removed | Biological Valve Replacement | Ovarian Cancer |
| Bladder Removed | Heart Transplant | Prostate Cancer |
| Mastectomy (Right, Left, Bilateral) | Joint Replacement, Knee
(Right, Left, Bilateral) | Prostate Biopsy |
| Lumpectomy (Right, Left, Bilateral) | Joint Replacement, Hip
(Right, Left, Bilateral) | TURP Skin Biopsy |
| Breast Biopsy (Right, Left, Bilateral) | Kidney Biopsy | Basal Cell Cancer Surgery |
| Breast Reduction | Kidney Removed (Right, Left) | Squamous Cell Cancer Surgery |
| Breast Implants | Kidney Stone Removal | Melanoma Surgery |
| Colon Cancer Resection Diverticulitis | Kidney Transplant | Spleen Removed |
| IBD | Ovaries Removed | Testicles Removed
(Right, Left, Bilateral) |
| Gallbladder Removed | Endometriosis | Fibroids Hysterectomy |
| Coronary Artery Bypass | Ovarian Cyst | Uterine Cancer |
| PTCA | | |
| Mechanical Valve Replacement | | |

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? _____

History of Smoking (circle one): Never Smoked Former Smoker Smokes Less Than Daily Smokes Daily

Is there anything else you'd like to share with us?

Patient/Guardian Name: _____

Signature: _____

Date: _____