2199 N. Merritt Creek Loop
Coeur d'Alene, ID 83814
niderm.com

**Medical** 208.665.7546
**Spa** 208.292.5939
**Fax** 208.667.4607

# 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: ______________

**Preferred Pharmacy:** ______________________________

**Primary Care Provider:** ______________________________

## Current problems with (circle all that apply):

Problems with bleeding
Problems with healing
Problems with scarring
Rash
Immunosuppression
Hay Fever
Chest Pain

Fever or Chills
Night Sweats
Unintentional Weight Loss
Thyroid Problems
Sore Throat
Blurry Vision
Abdominal Pain

Bloody Stool/Urine
Joint Aches
Muscle Weakness
Neck Stiffness
Headaches
Seizures
Cough

Shortness of Breath
Wheezing
Anxiety/Depression
Other:

## Alerts (circle all that apply):

Allergy to Latex
Allergy to Lidocaine
Allergy to Adhesive
Allergy to Topical antibiotic ointment
Artificial or Damaged Heart Valve
Defibrillator

Rapid Heartbeat with Epinephrine
Pacemaker
Blood Thinners
Premedication prior to procedures Artificial
Joints within the past two years Pregnant or
planning a pregnancy

## Past Medical History (circle all that apply):

None
Anxiety
Arthitis
Asthma
Atrial Fibrillation
BPH
Cereborvascular (Stroke)
COPD
Coronary Arterlosclerosis
Depressive Disorder
Diabetes

Diseased caused by COVID-19
Elevated Blood Pressure
End Stage Renal Disease
Epilepsy
GERD
Hearing Loss
HIV Infection
Hypercholesterolemia
Hyperthyroidism
Inflammatory Disease of Liver

Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Valve Replacement

MORE ON BACK

## Past Surgical History (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
Colon Cancer Resection Diverticulitis
IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA
Mechanical Valve Replacement
Biological Valve Replacement

Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed
Endometriosis
Ovarian Cyst
Ovarian Cancer
Prostate Cancer

Prostate Biopsy
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Cancer Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral) Fibroids
Hysterectomy
Uterine Cancer
Squamous Cell Skin Cancer
Hay Fever/Allergies
Other:

## Skin Disease History (circle all that apply):

Acne
Actinic Keratoses Asthma
Basal Cell Skin Cancer

Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp

Melanoma
Poison Ivy
Precancerous Moles
Psoriasis

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** (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:** ___________________________