Dermatology Associates
of Oakbrook Terrace

Today's Date: _____

NAME:_____ **DATE OF BIRTH:_____**

History and Intake Form

Past Medical History: (please circle all that apply & provide dates if known)

Anxiety
Arthritis
Asthma
Atrial fibrillation
BPH (Benign Prostatic Hyperplasia)
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD (Emphysema)
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD (Acid reflux)
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia (high cholesterol)
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
None
Other _____

Past Surgical History: (please circle all that apply & provide dates if known)

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
Coronary Artery Bypass
PTCA
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis

Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
None
Other _____

Skin Disease History: (please circle all that apply & provide dates if known)

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
Rosacea
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 history: _____

Medications: (Please enter all current medications & dosage)

_____
_____
_____
_____

Allergies: (Please enter all allergies)

_____
_____
_____
_____

Social History: (Please circle one)

Cigarette Smoking:
Never smoked
Quit: former smoker
Smokes less than daily
Smokes daily

Alcohol Use:
YES
NO
Socially

How often do you exercise?
Once a day
A few times a week
A few times a month
Never

What is your caffeine use?
Once a day
A few times a week
A few times a month
Never

Occupation and Workplace: _____

Place of Residence: Home(address on file) Assisted Living(Name)_____
Away at school Nursing Home(Name)_____

Language (primary):
English
Spanish
Other: _____

Race:
White
Black/African American
Asian
American Indian or Native Alaskan
Native Hawaiian/Pacific Islander

Ethnicity:
Hispanic/Latino
Non-Hispanic/Non-Latino

****All prescriptions will be sent electronically to your preferred pharmacy. Please designate primary and secondary if more than one pharmacy provided****

Pharmacy (Local): Name:_____
Street:_____ City: _____
Zipcode:_____ Phone#:_____

Mail Order Pharmacy: Name: _____
Street:_____ City: _____
Zipcode:_____ Phone#:_____