PINNACLE DERMATOLOGY
medical | surgical | cosmetic
A Division of Prime Medical Group, PLLC

Patient Medical History Intake Form

Today's Date: _____

Patient Name	Date of Birth

Reason for Today's Visit	
Primary Care Provider	Referring Physician (if applicable)
Preferred Pharmacy	Pharmacy Address and Phone Number

Do you authorize us to upload your prescriptions from your pharmacy? ☐ Yes ☐ No

Medical History (please check any conditions you are currently being treated for or have had in the past) ☐ None

☐	Anxiety Disorder	☐	Depressive Disorder	☐	History of Radiation Therapy	☐	Malignant Lymphoma
☐	Arthritis	☐	Diabetes Mellitus	☐	HIV	☐	Malignant Tumor of Breast
☐	Asthma	☐	Elevated Blood Pressure	☐	Hypercholesterolemia (High Cholesterol)	☐	Malignant Tumor of Colon
☐	Atrial Fibrillation	☐	End-Stage Renal Disease	☐	Hyperthyroidism	☐	Malignant Tumor of Prostate
☐	Cerebrovascular Accident (Stroke)	☐	Epilepsy (Seizures)	☐	Hypothyroidism	☐	Transplantation of Bone Marrow
☐	COPD	☐	History of Hypertension	☐	Immunosuppression	☐	Hepatitis B
☐	Coronary Artery Disease	☐	Hepatitis C	☐	Leukemia	☐	Other:
☐	Other:						

Past Surgical History (please check all past procedures or surgeries) ☐ No past procedures or surgeries

☐	Coronary Artery Disease	☐	History of Appendectomy	☐	Thyroidectomy
☐	Excision of Basal Cell Carcinoma	☐	History of Cholecystectomy (Gallbladder removed)	☐	Transplant of Kidney
☐	Excision of Melanoma	☐	History of Colectomy	☐	Transplantation of Heart
☐	Excision of Squamous Cell Carcinoma	☐	Hysterectomy	☐	Transplantation of Liver
☐	History of Artificial Joint	☐	Mechanical Heart Valve Replacement	☐	Other:
☐	Other:				

Skin Conditions and Skin Disease History (please check all that apply) ☐ None

☐	Acne	☐	Dysplastic Nevus Moles	☐	Psoriasis
☐	Actinic Keratosis	☐	Eczema	☐	Rosacea
☐	Basal Cell Skin Cancer	☐	History of Hay Fever / Allergies	☐	Squamous Cell Skin Cancer
☐	Contact Dermatitis	☐	Melanoma	☐	Sunburn of Second Degree
☐	Other:				

Do you wear Sunscreen? ☐ Yes ☐ No If yes, what SPF? _____	Do you or have you tanned in a tanning bed? ☐ Yes ☐ No

Do you have a family history of Melanoma? ☐ Yes ☐ No
If yes, which relative(s)? _____

Current Medications (include non-prescription products and supplements) ☐ None

Medication	Strength (dosage)	Frequency	Route (oral, topical, etc.)	Diagnosis Why do you take this medication?

Today's Date: _____

Patient Name	**Date of Birth**

Allergies (include medication, food, latex, and environmental allergies) ☐ No known allergies

Allergy	**Type of Reaction** (Check all that apply)
	☐ Itching ☐Swelling ☐Hives ☐Rash ☐Difficulty Breathing ☐Anaphylaxis ☐Other: _____
	☐ Itching ☐Swelling ☐Hives ☐Rash ☐Difficulty Breathing ☐Anaphylaxis ☐Other: _____
	☐ Itching ☐Swelling ☐Hives ☐Rash ☐Difficulty Breathing ☐Anaphylaxis ☐Other: _____
	☐ Itching ☐Swelling ☐Hives ☐Rash ☐Difficulty Breathing ☐Anaphylaxis ☐Other: _____

Are you a tobacco smoker?	Alcohol Intake
☐ Current Smoker ☐ Former Smoker ☐ Never	☐ None ☐ 1 or Less Per Day ☐ 1-2 Per Day ☐ 3 or More Per Day

Patients 65 Years and Older – Advanced Care Plan (if you are 65 years or older, please answer the following questions)

Do you have a health care proxy in the event you are unable to make your own medical decisions? ☐ Yes ☐ No
Designee Name _____ Designee Phone Number _____
Do you have a living will? ☐ Yes ☐ No
Have you had a Pneumonia Vaccine? ☐ Yes ☐ No

Patients Turning 13 Years Old This Year – Immunizations for Adolescents (if the patient is turning 13 years old this year, please answer the following questions)

Has the patient had a meningococcal vaccine on or between the patient's 11th and 13th birthdays? ☐ Yes ☐ No
Has the patient had a tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) on or between the patient's 10th and 13th birthdays? ☐ Yes ☐ No
Has the patient completed the HPV vaccine series on or between the patient's 9th and 13th birthdays? ☐ Yes ☐ No
If **no** was answered to any of the above, did the patient have an anaphylaxis reaction due to one of the above vaccines any time on or before the patient's 13th birthday? ☐ Yes ☐ No

Review of Systems (please check all that apply) ☐ None

☐	Problems with Bleeding/Bruising	☐	Unintentional Weight Loss	☐	Bloody Urine
☐	Problems with Scarring	☐	Fever or Chills	☐	Joint Aches
☐	Skin Rashes	☐	Night Sweats	☐	Muscle Weakness
☐	Headaches	☐	Abdominal Pain		
☐	Seasonal Allergies	☐	Bloody Stool		

Alerts (please check all that apply) ☐ None

☐	Allergy to Adhesive/Tape	☐	Artificial Joints (within past two years)	☐	HIV
☐	Allergy to Latex	☐	Blood Thinners	☐	MRSA
☐	Allergy to Lidocaine	☐	Currently Breastfeeding	☐	Premedication Prior to Procedures
☐	Allergy to Topical Antibiotic Ointment	☐	Defibrillator/Pacemaker	☐	Pregnancy or Planning a Pregnancy
☐	Artificial Heart Valve	☐	Hepatitis B or C	☐	Rapid Heartbeat with Epinephrine

Updated 9.23.2024