PINNACLE DERMATOLOGY
medical | surgical | cosmetic

HISTORY INTAKE FORM

Name _____ **Date of Birth** _____ **Today's Date** _____

Primary Care Provider _____

Name of Referring Medical Professional _____

Reason for today's visit _____

The federal government has defined a complete electronic medical record (EMR) or electronic health record (EHR) as containing four basic functions: computerized orders for prescriptions, computerized orders for tests, reporting of test results, and physician notes. Providers must attest to demonstrating "meaningful use" of these functions every year to avoid payment adjustment penalties. Providers have to show that they are "meaningfully using" their EHRs by meeting thresholds for a number of objectives. As part of the objectives we are having our patients complete these medical history questions and demographic information so that we may qualify for "meaningful use".

Past Medical History (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone Marrow Transplant
Breast Cancer
Colon Cancer
COPD/Emphysema
Coronary Artery Disease
Other_____
Other
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
High Blood pressure
HIV/AIDS
High Cholesterol
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatments
Seizures
Stroke
Thyroid Disease

NONE

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
Coronary Artery Bypass
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Other_____
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy (Nephrectomy)
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 (Prostate Removal)
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer

Name:_____**DOB:**_____**Date:**_____

Skin Disease History (please circle all that apply)

Acne
Actinic Keratoses
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Other _____

Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer

NONE

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)? _____

Medications (Please enter all current medications, supplements and OTC medications;
Include: **Name, Dose, How often, Form(such as tablet) and the Diagnosis in which you take it**)

Medication	Strength	Frequency	Route	Diagnosis

Allergies (Please enter all allergies and type of reaction for each)

_____

_____

Social History (Please circle all that apply)

Cigarette/Tobacco Use:
Never used
Former user
Current user
How many years? _____
Packs per day? _____

Alcohol Use:
None
less than 1 drink per day
1-2 drinks per day
3 or more drinks per day

Occupation _____

Preferred Language _____ **Race/Ethnic Group** _____

Name:_____**DOB:**_____**Date:**_____

Family Medical History (Only first-degree relatives: parents, siblings, children):

_____

_____

_____

Preferred Pharmacy Name _____

Address _____

Phone#: _____

Review of Symptoms - Are you ***currently*** experiencing any of the following? (Please check yes or no)

Symptom	Yes	No	Symptom	Yes	No
Problems with bleeding			Active hepatitis C		
Problems with healing			Abdominal pain		
Problems with scarring			Bloody stool		
Rash			Bloody urine		
Immunosuppression			Joint aches		
Hay fever			Muscle weakness		
Chest pain			Neck stiffness		
Fever or chills			Headache		
Night sweats			Seizures		
Unintentional weight loss			Cough		
Thyroid problems			Shortness of breath		
Sore throat			Wheezing		
Ear pain			Anxiety		
Blurry vision			Depression		

Other Symptoms: _____

Have you ever had a Pneumonia Vaccine? Y N
Have you had your flu shot this year? Y N

ALERTS (please circle all that apply)

Allergy to Adhesive
Allergy to lidocaine
Allergy to topical antibiotics
Artificial heart valve
Artificial joint replacement
Blood thinners
Defibrillator
MRSA
Pacemaker
Require antibiotics prior to surgical procedure
Rapid heartbeat with epinephrine
Pregnant or currently trying to get pregnant? Yes No
Currently breastfeeding? Yes No