CAROLINAS SKIN CENTER

PLASTIC & DERMATOLOGIC SURGERY

Patient Intake and History Form

Please complete all questions. Be advised that completing preliminary health and insurance questionnaires does not establish a physician---patient relationship with this practice. An initial evaluation is required to determine whether you are a suitable candidate and whether the practice will accept you as a patient

Patient Name (Last, First, MI)	Date of Birth	Date
Address	City/State/Zip	Male _____ Female ____
Email	Preferred Language	Ethnicity: Race:
Home Phone ( )	Cell Phone ( )	Preferred Contact Method
Height Weight	Referring Doctor	Primary Doctor

Skin Cancer History	Diagnosis	Location	Treatment Date and Method
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PAST MEDICAL HISTORY: Circle Yes or No if YOU currently have any of the following conditions? ☐ No known past medical history.

CONDITION	PATIENT
Anxiety	Yes No
Arthritis	Yes No
Asthma	Yes No
A Fib *(irregular heartbeat)*	Yes No
BPH *(enlarged prostate)*	Yes No
Bone Marrow Transplant	Yes No
Breast Cancer	Yes No
Colon Cancer	Yes No
COPD	Yes No
Coronary Artery Disease	Yes No

CONDITION	PATIENT
Depression	Yes No
Diabetes	Yes No
Kidney Disease	Yes No
Gastric Reflux	Yes No
Hearing Loss	Yes No
Hepatitis	Yes No
*High Blood Pressure	Yes No
Controlled w/Medication	Yes No
HIV/AIDS	Yes No
High Cholesterol	Yes No

CONDITION	PATIENT
Hyperthyroidism	Yes No
Hypothyroidism	Yes No
Leukemia	Yes No
Lung Cancer	Yes No
Lymphoma	Yes No
Prostate Cancer	Yes No
Radiation Treatment	Yes No
Seizures	Yes No
Stroke	Yes No
Other:	

PAST SURGICAL HISTORY: Have you ever had the following? ☐ No surgeries

Functional Status Test: Please provide the date you followed up with your provider/surgeon after your joint replacement.

☐ Appendix Removal (Appendectomy)	☐ Colon (Colectomy): Diverticulitis	☐ Ovaries (Oophorectomy): Endometriosis
☐ Bladder Removal (Cystectomy)	☐ Colon (Colectomy): IBD	☐ Ovaries (Oophorectomy): Ovarian Cyst
☐ Breast: Mastectomy (Right Breast)	☐ Gallbladder (Cholecystectomy)	☐ Ovaries (Oophorectomy): Ovarian Cancer
☐ Breast: Mastectomy (Left Breast)	☐ Heart: Bypass Surgery	☐ Prostate (Prostatectomy): Prostate Cancer
☐ Breast: Mastectomy (Both Breasts)	☐ Heart: PTCA	☐ Prostate: Prostate Biopsy
☐ Breast: Lumpectomy (Right Breast)	☐ Heart: Mechanical Valve Replacement	☐ Prostate: TURP
☐ Breast: Lumpectomy (Left Breast)	☐ Heart: Biological Valve Replacement	☐ Skin Biopsy
☐ Breast: Lumpectomy (Both Breasts)	☐ Heart: Heart Transplant	☐ Spleen Removal (Splenectomy)
☐ Breast: Breast Biopsy	☐ Kidney: Kidney Biopsy	☐ Testicles Removal (Orchiectomy)
☐ Breast: Breast Reduction	☐ Kidney: Removal/Nephrectomy	☐ Uterus (Hysterectomy): Fibroids
☐ Breast: Breast Implants	☐ Kidney: Kidney Stone Removal	☐ Uterus (Hysterectomy): Uterine Cancer
☐ Colon (Colectomy): Colon Cancer	☐ Kidney: Kidney Transplant	☐ Other Surgeries:

SKIN HISTORY: Have you ever had or have the following? ☐ No skin condition history

☐ Acne	☐ Dry Skin	☐ Poison Ivy
☐ Actinic Keratoses (Pre---cancers)	☐ Eczema	☐ Precancerous Moles
☐ Asthma	☐ Flaking or Itchy Scalp	☐ Psoriasis
☐ Basal Cell Carcinoma	☐ Hay Fever/Allergies	☐ Squamous Cell Carcinoma
☐ Blistering Sunburns	☐ Melanoma	
☐ Other Skin Conditions:		

Gynecologic History Last Menstrual Period_____ Last Mammogram_____ Results_____

Currently pregnant Yes____ No____ Number of pregnancies ____ Number of births____

Do you wear sunscreen? □ Yes □ No If yes, what SPF?

Do you go to tanning salons? Yes No

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

Family History of malignant hyperthermia Yes No Personal history of severe reaction to anesthesia Yes No

***MEDICATIONS: List your medications. Please include all Rx, OTC, herbal, and vitamin supplements.**

Medication Name	Dose *(example: 100 mg)*	Route	Frequency *(example: once a day)*	Start Date/End Date

ALLERGIES: List your allergies and reaction.

Medication or Allergen	Reaction *(example: rash, GI upset, etc.)*

SOCIAL HISTORY: Check best response.

*Smoking Status? □ Every day smoker □ Some day smoker □ Former Smoker □ Never Smoker

Weekly alcohol consumption? □ None □ Less than 1 drink/day □ 1---2 drinks/day □ 3 or more drinks/day

REVIEW OF SYSTEMS: Have you had any of the following in the past year? □ No Symptoms

Abdominal Pain	Yes	No	Easy Bleeding or Bruising	Yes	No	Night Sweats	Yes	No
Anxiety	Yes	No	Fevers or Chills	Yes	No	Problems with Scarring (keloids)	Yes	No
Blood in Stool	Yes	No	Hair Loss	Yes	No	Rash	Yes	No
Blood in Urine	Yes	No	Hay Fever	Yes	No	Seizures	Yes	No
Chest Pain	Yes	No	Headaches	Yes	No	Sensitivity to Light or Sunburn Easily	Yes	No
Cough	Yes	No	Immunosuppression	Yes	No	Shortness of Breath	Yes	No
Depression or Sad Mood	Yes	No	Joint Aches	Yes	No	Sore Throat	Yes	No
Diarrhea	Yes	No	Mouth Ulcers	Yes	No	Thyroid Problems	Yes	No
Difficulty Healing Wounds	Yes	No	Muscle Weakness	Yes	No	Unintentional Weight Loss	Yes	No
Dry Eyes	Yes	No	Neck Stiffness	Yes	No	Vision Changes or Blurred Vision	Yes	No
Other Symptoms:								

ALERTS: Please answer the following important questions.

Are you allergic to adhesives or tape?	Yes	No	Do you have a defibrillator?	Yes	No
Are you allergic to numbing medicines?	Yes	No	Do you have a history of MRSA infections?	Yes	No
Are you allergic to antibiotic creams?	Yes	No	Do you have a pacemaker?	Yes	No
Do you have an artificial heart valve?	Yes	No	Do you require antibiotic prior to procedures?	Yes	No
Have you had a joint replaced in last 2 years?	Yes	No	Do you get a rapid heartbeat with numbing medicine?	Yes	No
Are you on any blood thinners?	Yes	No	Are you pregnant or planning to become pregnant?	Yes	No

FAMILY MEDICAL HISTORY: Please list major medical conditions of first---degree relatives.

Father	Mother
Sister(s)	Brother(s)