MAGNOLIA
DERMATOLOGY

PATIENT HISTORY AND INTAKE FORM

Patient Information: Today's Date: _____

Last Name: _____ First Name: _____ Middle: ____

Preferred Name: _____ Date of Birth: _____ Age: _____

How did you hear about us?: _____

Due to Federal EMR regulations, all areas with an asterisk must be filled out, including Ethnicity.

*** Gender**: ☐ Male ☐ Female *** Preferred Language:** _____

*** Race**: ☐ African American ☐ American Indian ☐ Asian ☐ White ☐ Other Race ☐ Decline to specify

*** Ethnicity:** ☐ Hispanic or Latino ☐ Non Hispanic or Latino ☐ Decline to specify

May we leave a detailed message on your phone? ☐ Yes ☐ No

Pharmacy:

Pharmacy Name: _____City: _____

Street: _____ Phone Number: _____

History of Present Skin Complaint:

What is your primary skin concern / reason for today's visit?

_____

Where on your body is the problem located?

_____

Describe any symptoms (bleeding, growing, itchy, painful, burning, rough, scaly, red, not healing, asymptomatic)

_____

How severe is the problem? ☐ Mild ☐ Moderate ☐ Severe

How long have you had the problem? _____Days _____Weeks _____Months _____Years

Describe any past treatment for this problem (OTC / RX / Surgery).

_____

Medical History: Please mark all that apply ☐ **NONE**

☐ Anxiety	☐ Depression	☐ HIV/AIDS
☐ Arthritis	☐ Diabetes	☐ High Cholesterol
☐ Asthma	☐ End Stage Renal Disease	☐ Hyperthyroidism
☐ Atrial Fibrillation	☐ GERD	☐ Hypothyroidism
☐ Bone Marrow Transplant	☐ Hearing Loss	☐ Seizures
☐ COPD	☐ Hepatitis	☐ Stroke
☐ Coronary Artery Disease	☐ High Blood Pressure	

☐ Cancer: (type) _____

Other:

_____

Last Menstrual Cycle: _____

Past Surgeries: ☐ **NONE**

Have you had any previous surgeries? If so, what and when?

_____

_____

Date: _____ Name: _____ DOB: _____

PATIENT HISTORY AND INTAKE FORM (continued)

Skin Disease History: Please mark all that apply ☐ **NONE**

☐ 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
☐ Squamous Cell Skin Cancer

Other:

_____

Do you wear sunscreen? (YES / NO) What SPF? _____ Do you tan in a tanning salon? (YES / NO)

Do you have a family history of Melanoma? (YES / NO) Which relative(s):_____

Medications/Vitamins/OTC Supplements: (Please provide a list of all current medications.)

☐ NO MEDICATIONS

_____

_____

_____

Drug Allergies: (Please list medication and describe reaction.)

☐ NO KNOWN DRUG ALLERGIES

_____

Social History:

Smoking status: ☐ Current every day ☐ Current someday ☐ Former smoker ☐ Never smoked

Alcohol use: ☐ None ☐ <1 drink per day ☐ 1-2 drinks per day ☐ 3 or more drinks per day

Occupation: _____ Employer:_____

Hobbies:_____

Family History: Please mark all that apply ☐ **NONE**

Diabetes	☐ Mom	☐ Dad	☐ Sister	☐ Brother	☐ Daughter	☐ Son
High Cholesterol	☐ Mom	☐ Dad	☐ Sister	☐ Brother	☐ Daughter	☐ Son
High Blood Pressure	☐ Mom	☐ Dad	☐ Sister	☐ Brother	☐ Daughter	☐ Son
Stroke	☐ Mom	☐ Dad	☐ Sister	☐ Brother	☐ Daughter	☐ Son

Additional Family History:

_____

Review of Systems:

Do you have any of the following? ☐ **NONE**

☐ Fatigue
☐ Fever
☐ Joint Pain
☐ Immunosuppression
☐ Problem with Bleeding
☐ Problems with Healing
☐ Problems with Scarring (Hypertrophic or Keloid)
☐ Recent Increase in Level of Stress

Alerts: Please mark all that apply ☐ **NONE**

☐ Allergy to Adhesive
☐ Allergy to Latex
☐ Allergy to Lidocaine
☐ Allergy to Topical Antibiotics
☐ Artificial Heart Valve
☐ Artificial Joints -within past 2yrs
☐ Breastfeeding
☐ Defibrillator
☐ MRSA
☐ Pacemaker
☐ Pregnancy or Planning Pregnancy
☐ Rapid heartbeat with Epinephrine
☐ Require Antibiotics Prior to Procedures

☐ Blood Thinners – Aspirin / Plavix / Coumadin / Xarelto / Pradaxa / Naproxen / Fish Oil / Vitamin E / Eliqvis

Other: _____

Thank you!