Bay Area Dermatology Medical Intake

Date:_____

Patient Name:_____ **DOB:**_____
Marital Status: Single, Married
Race: (circle one) White, Black/African American, Asian, American Indian or Native Alaskan, Native Hawaiian/Pacific Islander
Ethnicity: Hispanic/Latino, Non-Hispanic Latino

Pharmacy: _____**Location/phone#**_____

Emergency Contact: Name:_____ Phone:_____
Preferred Contact Method: _____

Past Medical History: (circle all that apply)

Anxiety	Arthritis	Artificial Joints
Asthma	Atrial Fibrillation	BPH/enlarged prostate
Cancer/Type_____	Colitis	COPD/Emphysema
Coronary Artery Disease	Defibrillator/Pacemaker	Depression
Diabetes	End Stage Renal Disease	GERD/ulcers
Hearing Loss	Hepatitis	Hypertension
HIV/AIDS	Hypercholesterolemia	Hyperthyroidism
Hypothyroidism	Lupus	Organ Transplant
Radiation Treatment	Seizures	Stroke
Tuberculosis	Valve Replacement	

Other medical conditions:_____

Past Surgical History: (list)
_____

_____

Skin Disease History: (circle all that apply)

Actinic Keratoses	Basal Cell Skin Cancer	Blistering Sunburns Eczema
Hayfever/Allergies	Melanoma	
Precancerous Moles	Psoriasis	Squamous Cell Skin Cancer

Other _____

Family History: Melanoma ☐ Yes ☐ No ~ If yes, which relative? _____

Other Family History_____

Medications: (include OTC)_____

_____

Allergies:_____

Social History: (circle one)
Cigarette Smoking: Never smoked, Quit, Smoke daily, Smoke less than daily

Alcohol Use: None, <1 drink daily, 1-2 drinks daily, 3 or more drinks daily

Occupation _____***Hobbies*** _____

Residence: (circle) Live alone in house/apt, live with family, live with other person(s), live in assisted living, live in nursing home