Name: ______________________________
Date of Birth: _________________________
Primary Physician __________________

Dermatology • Mohs • Facial Plastic Surgery

HISTORY AND INTAKE FORM

Past Medical History: (please CHECK all that apply)

☐ Anxiety	☐ Uterine Cancer	☐ Heart Attack	☐ Tuberculosis
☐ Arthritis	☐ COPD	☐ HIV/AIDS	☐ Bone Marrow Transplantation
☐ Asthma	☐ Depression	☐ High Cholesterol	☐ Coronary Artery Disease
☐ Atrial fibrillation	☐ Diabetes	☐ Leukemia	☐ End Stage Renal Disease
☐ Breast Cancer	☐ Endometriosis	☐ Lymphoma	☐ High Blood pressure
☐ Colon Cancer	☐ Uterine Fibroids	☐ Seizures	
☐ Lung Cancer	☐ GERD	☐ Stroke	
☐ Prostate Cancer	☐ Hearing Loss	☐ Radiation Treatment	
☐ Ovarian Cancer	☐ Hepatitis ☐ A ☐ B ☐ C	☐ Thyroid Problems	☐ **NONE**

Other ____

Past Surgical History: (please CHECK all that apply. Include YEAR of procedure,
If applicable, CHECK the reason for surgery; R= right, L= left, B= Bilateral)

☐ Anesthetic Complications	☐ Colon Resection:	☐ R L B Joint Replacement	☐ Organ Transplant:
☐ Appendix Removed	☐ Colon Cancer	☐ Knee	☐ Heart
☐ Bladder Removed	☐ Diverticulitis	☐ Hip	☐ Liver
☐ R L B Mastectomy	☐ IBD	☐ other:	☐ Kidney
☐ R L B Lumpectomy	☐ Hysterectomy:	☐ Kidney Stone Removal	☐ Other
☐ R L B Breast Biopsy	☐ Fibroids	☐ Kidney Biopsy	☐ Breast Reduction
☐ Coronary Artery Bypass	☐ Uterine Cancer	☐ R L B Kidney Removed	☐ Breast Implants
☐ Heart Valve Replacement	☐ Ovaries Removed:	☐ Prostate Biopsy	☐ Botox
☐ Gallbladder Removed	☐ Cyst	☐ Prostate Removed:	☐ Fillers
☐ Spleen Removed	☐ Endometriosis	☐ Prostate Cancer	☐ Eyelid surgery
☐ Ear tubes	☐ Ovarian Cancer	☐ TURP (Prostate Removal)	☐ Facelift
☐ Tonsillectomy		☐ R L B Testicles Removed	☐ Rhinoplasty
☐ Sinus Surgery			☐ **NONE**

Skin Disease History: (please CHECK all that apply)

☐ Blistering Sunburns	☐ Asthma	☐ Flaking or Itchy Scalp	☐ Precancerous Moles
☐ Acne	☐ Dry Skin	☐ Hay Fever/Allergies	☐ Psoriasis
☐ Actinic Keratosis	☐ Eczema	☐ Poison Ivy	☐ Other: ______________

Skin Cancer:

☐ Melanoma	☐ Squamous Cell Skin Cancer	☐ Basal Cell Skin Cancer	☐ Other: ______________

Details of Skin Cancer (Which part of body?, What year?):_______________________________________

Previous Mohs (skin cancer surgery): ____
Do you wear Sunscreen/Moisturizer? ☐ Yes ☐ No If yes: What SPF? _________ Which Brand?________________
Do you tan in a tanning salon? ☐ Yes ☐ No
Describe your daily skin care regime: ____

1235 N. Mulford Rd. Suite 205, Rockford IL 61107
Phone: 815.484.9900
www.mdskinrockford.com

Name: ______________________________
Date of Birth: _______________________
Primary Physician _________________

Medications: (Please enter all current medications or attach list)

____
____
____

Allergies: (Please enter all allergies or attach list)

____
____
____

Social History: (Please CHECK all that apply)

Cigarette Smoking:	**Alcohol Use:**	**Family History Melanoma**	
☐ Currently Smokes	☐ None	☐ Mother	☐ Father
☐ Has smoked in the past	☐ less than 1 drink per day	☐ Sister	☐ Brother
☐ Never smoked	☐ 1-2 drinks per day	☐ Daughter	☐ Son
☐ Former Smoker	☐ 3 or more drinks per day		

Review of Systems: (Please CHECK all that apply) **ALERTS**: (Please CHECK all that apply)

☐ Fever	☐ rapid change in vision		☐ Allergy to adhesive
☐ Chills	☐ Foul nasal odor		☐ Allergy to latex
☐ unintentional wt loss >10lbs	☐ chest pain		☐ Allergy to lidocaine
☐ Increased infections	☐ Irregular Heartbeat		☐ Allergy to shellfish/iodine
☐ Unusual scarring	☐ Cough		☐ Allergy to topical antibiotics
☐ poor healing	☐ Shortness of breath		☐ Blood thinners
☐ Excessive bleeding	☐ Nausea		☐ Require antibiotics prior to surgery
☐ easy bruising	☐ Vomiting		☐ Artificial joint replacement
☐ unusual memory loss	☐ Abdominal pain		☐ Artificial heart valve
☐ recent leg swelling	☐ Bleeding with urination		☐ Defibrillator
☐ cold intolerance	☐ Panic attacks		☐ Pacemaker
			☐ Pregnant or Trying to get pregnant
			☐ MRSA

Other miscellaneous data the Centers for Medicare Services wants medical clinics to obtain:

Preferred Language: ☐ English ☐ Spanish ☐ Other:______________________

Race: ☐ Asian ☐ Black ☐ Hispanic/Latino ☐ White ☐ Other______________________________
☐ Prefer to Decline this question

Email Address: ____

Employer's Name: ___________________________ Occupation:_________________________________

Preferred pharmacy: ☐ CVS ☐ Nihan Martin ☐O'Brien & Dobbins ☐ Schnuck's ☐ Shopko ☐ Snyder
☐ Target ☐ Walgreens ☐ Walmart Other: ______________________________

Please specify which pharmacy:
Phone#: ___________________________
Street: ___________________________
City or Zip code: ___________________

Height: _________________
Weight: _________________

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