Intake Form

NW MD
NORTHWESTERN MICHIGAN DERMATOLOGY, PC

Name: _____ Date: _____
Date of Birth: _____ Sex: □ Female □ Male
Referred By: _____Primary Physician:_____
Previous Dermatologist:_____
Preferred Pharmacy (Name and Location): _____

SECTION I: HEALTH HISTORY

Past Medical History (as diagnosed by a physician):

Anxiety.....☐ Yes ☐ No
Arthritis .....☐ Yes ☐ No
Asthma .....☐ Yes ☐ No
Atrial fibrillation (irregular heartbeat) .....☐ Yes ☐ No
Cerebrovascular accident (stroke) .....☐ Yes ☐ No
COPD .....☐ Yes ☐ No
COVID Vaccine……☐Yes ☐ No
Coronary arteriosclerosis .....☐ Yes ☐ No
Depressive disorder .....☐ Yes ☐ No
Diabetes .....☐ Yes ☐ No
Disease related to COVID -19……..☐Yes ☐ No
Elevated blood pressure .....☐ Yes ☐ No
End-stage renal disease .....☐ Yes ☐ No
Epilepsy.....☐ Yes ☐ No
Hearing loss .....☐ Yes ☐ No
HIV……...☐Yes ☐ No
Hypercholesterolemia (high cholesterol).....☐ Yes ☐ No
Hyperthyroidism .....☐ Yes ☐ No
Hypothyroidism.....☐ Yes ☐ No
Inflammatory disease of liver.....☐ Yes ☐ No
Leukemia.....☐ Yes ☐ No
Malignant lymphoma .....☐ Yes ☐ No
Malignant tumor of lung.....☐ Yes ☐ No
Malignant tumor of breast.....☐ Yes ☐ No
Malignant tumor of colon.....☐ Yes ☐ No
Malignant tumor of prostate.....☐ Yes ☐ No
Radiation therapy .....☐ Yes ☐ No
Transplant of bone marrow .....☐ Yes ☐ No
Transplant of organ .....☐ Yes ☐ No
*If yes, type*_____

List all other medical conditions:_____

Surgeries: Please list all surgeries you've had in the past 12 months:_____
_____
_____
_____

Past Skin Disease History:

Acne ..... ☐ Yes ☐ No
Actinic keratoses (pre-cancers)..... ☐ Yes ☐ No
Asteatosis cutis (eczema) ..... ☐ Yes ☐ No
Basal cell carcinoma ..... ☐ Yes ☐ No
Contact dermatitis due to poison ivy ..... ☐ Yes ☐ No
Dysplastic nevus ..... ☐ Yes ☐ No
Malignant melanoma..... ☐ Yes ☐ No
Pneumonia Vaccine……☐Yes ☐ No
Psoriasis..... ☐ Yes ☐ No
Squamous cell carcinoma..... ☐ Yes ☐ No
Sunburn of second degree..... ☐ Yes ☐ No
Shingles..... ☐ Yes ☐ No
Shingles vaccine ..... ☐ Yes ☐ No
If yes, year _____

Family History of Non-Melanoma Skin Cancer
(Basal Cell Cancer, Squamous Cell Cancer)
_____
_____
_____

Family History of Melanoma..... ☐ Yes ☐ No
If yes, which relatives?
_____
_____
_____

Other: _____

Do you wear sunscreen? ☐ Yes ☐ No If yes, what SPF? _____ Do you tan in a tanning salon? ☐ Yes ☐ No

Continued on other side

List ALL **Medications** you are currently taking:

Name	Dosage	How Often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you **allergic** to any medications? □ YES □ NO If yes, please list:

Name	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

Smoking Status:

☐ Never
☐ Former Smoker
☐ Current every day smoker
☐ Current some day smoker
☐ Smoker current status unknown

Do you drink alcohol? □ YES □ NO If YES_____ drinks per day.

SECTION II: REVIEW OF SYSTEMS

Check below any that apply:

☐ Allergy to adhesives
☐ Allergy to latex
☐ Allergy to topical antibiotic ointments
☐ Artificial heart valve
☐ Defibrillator
☐ Pacemaker
☐ Blood thinners
☐ HIV
☐ Artificial joints
☐ Hepatitis C
☐ Problems with local anesthesia
☐ Immunosuppression
☐ Fever or chills
☐ Night sweats
☐ Unintentional weight loss or gain
☐ Sore throat
☐ Blurry vision
☐ Abdominal pain
☐ Bloody stool
☐ Bloody urine or kidney problems
☐ Anemia
☐ Blood clots
☐ Leg swelling
☐ Problems with bleeding
☐ Problems with healing
☐ Problems with scarring (hypertrophic or keloid)
☐ Joint aches
☐ Muscle weakness
☐ Headaches
☐ Pregnancy or planning a pregnancy
☐ Fainting
☐ HSV
☐ Cough
☐ Shortness of breath

COMPLETED BY: _____ **TODAY'S DATE:** _____
(Patient or Parent/Guardian if patient is a minor)

Entered by **MA/LPN/RN** _____ (initials)