



# SPECTRUM

DERMATOLOGY OF SEATTLE

## HISTORY AND INTAKE FORM

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Preferred Pronouns:  He/Him  She/Her  They/Them  \_\_\_\_\_

### Past Medical History: (please check all that apply)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Anxiety                 | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Lymphoma                       |
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> Opioid Dependence              |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> GERD                    | <input type="checkbox"/> Prostate Cancer                |
| <input type="checkbox"/> Atrial Fibrillation     | <input type="checkbox"/> Hearing Loss            | <input type="checkbox"/> Radiation Treatment            |
| <input type="checkbox"/> Bone Marrow             | <input type="checkbox"/> Hepatitis               | <input type="checkbox"/> Seizures                       |
| <input type="checkbox"/> Breast Cancer           | <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Stroke                         |
| <input type="checkbox"/> Colon Cancer            | <input type="checkbox"/> HIV / AIDS              | <input type="checkbox"/> Thyroid problems: hyper / hypo |
| <input type="checkbox"/> COPD                    | <input type="checkbox"/> High Cholesterol        | <input type="checkbox"/> Transplant                     |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Leukemia                |   |
| <input type="checkbox"/> Depression              | <input type="checkbox"/> Lung Cancer             |   |

Other: \_\_\_\_\_

### Past Surgical History: (please check all that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> Appendix Removed                                 | <input type="checkbox"/> Joint Replacement , Hip (Right, Left, Bilateral) |
| <input type="checkbox"/> Bladder Removed                                  | <input type="checkbox"/> Joint Replacement within last 2 years            |
| <input type="checkbox"/> Mastectomy (Right, Left, Bilateral)              | <input type="checkbox"/> Kidney Biopsy                                    |
| <input type="checkbox"/> Lumpectomy (Right, Left, Bilateral)              | <input type="checkbox"/> Kidney Removed (Right, Left)                     |
| <input type="checkbox"/> Breast Biopsy (Right, Left, Bilateral)           | <input type="checkbox"/> Kidney Stone Removal                             |
| <input type="checkbox"/> Breast Reduction                                 | <input type="checkbox"/> Kidney Transplant                                |
| <input type="checkbox"/> Breast Implants                                  | <input type="checkbox"/> Ovaries Removed: Endometriosis                   |
| <input type="checkbox"/> Colectomy: Colon Cancer Resection                | <input type="checkbox"/> Ovaries Removed: Cyst                            |
| <input type="checkbox"/> Colectomy: Diverticulitis                        | <input type="checkbox"/> Ovaries Removed: Ovarian Cancer                  |
| <input type="checkbox"/> Colectomy: IBD                                   | <input type="checkbox"/> Prostate Removed: Prostate Cancer                |
| <input type="checkbox"/> Gallbladder Removed                              | <input type="checkbox"/> Prostate Biopsy                                  |
| <input type="checkbox"/> Coronary Artery Bypass                           | <input type="checkbox"/> TURP (Prostate Removal)                          |
| <input type="checkbox"/> Mechanical Valve Replacement                     | <input type="checkbox"/> Spleen Removed                                   |
| <input type="checkbox"/> Biological Valve Replacement                     | <input type="checkbox"/> Testicles Removed (Right, Left, Bilateral)       |
| <input type="checkbox"/> Heart Transplant                                 | <input type="checkbox"/> Hysterectomy: Fibroids                           |
| <input type="checkbox"/> Joint Replacement, Knee (Right, Left, Bilateral) | <input type="checkbox"/> Hysterectomy: Uterine Cancer                     |

Other: \_\_\_\_\_

**Skin Disease History: (please check all that apply)**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Acne                   | <input type="checkbox"/> Cold Sores (oral herpes) | <input type="checkbox"/> Poison Ivy                |
| <input type="checkbox"/> Actinic Keratosis      | <input type="checkbox"/> Eczema                   | <input type="checkbox"/> Precancerous Moles        |
| <input type="checkbox"/> Allergies / Hay Fever  | <input type="checkbox"/> Flaking or Itchy Scalp   | <input type="checkbox"/> Psoriasis                 |
| <input type="checkbox"/> Basal Cell Skin Cancer | <input type="checkbox"/> Genital Herpes           | <input type="checkbox"/> Squamous Cell Skin Cancer |
| <input type="checkbox"/> Blistering Sunburns    | <input type="checkbox"/> Melanoma                 | <input type="checkbox"/> Shingles                  |

Other: \_\_\_\_\_

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

Do you tan in a tanning salon? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you have a family history of Melanoma? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If yes, which relative(s)? \_\_\_\_\_

**Medications: (please list all current medications, vitamins, and herbs)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Allergies: (please enter all allergies and reaction type, ie. rash, swelling etc.)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Social History:**

Cigarette Smoking: \_\_\_\_\_ Currently Smoke \_\_\_\_\_ Former Smoker \_\_\_\_\_ Never Smoked

Alcohol Use: \_\_\_\_\_ Never \_\_\_\_\_ Less than 1 drink/day \_\_\_\_\_ 1-2 drinks/day \_\_\_\_\_ 3 or more drinks/day

**NON- skin related Family History: Please list relative and what type of medical issue they currently have or have had in the past (only list first-degree relatives, *example: mom, dad, siblings*).**

*Example: Dad, Diabetes. Mom, Lung Cancer*

Family Member:

Medical Issue:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Preferred Language:  English  Spanish Other: \_\_\_\_\_

Ethnicity\*:  Hispanic or Latino  Not Hispanic or Latino  Unknown  Decline to Specify

Race\*:  American Indian/Alaska Native  Asian  Black/African American  White  Native  
 Hawaiian/Other Pacific Islander  Other  Decline to Specify

*\*Please note that this information is requested per government regulations. If you rather not provide the information, please select "Decline to Specify."*

**Review of Systems:** Are you currently experiencing any of the following?

Symptom	Yes	No
Problems with bleeding		
Problems with healing		
Problems with scarring (hypertrophic or keloid)		
Rash		
Immunosuppression		
Hay fever		
Fever or chills		
Night sweats		
Unintentional weight loss		
Blurry vision		
Abdominal pain		
Joint aches		
Headaches		
Shortness of breath		
Anxiety		
Depression		
Painful Urination		

Other Symptoms: \_\_\_\_\_

**Alerts:** (Please circle all that apply)

Allergy to Adhesive  
Allergy to Lidocaine  
Allergy to topical antibiotics  
Artificial heart valve  
Artificial joint replacement  
Blood thinners  
Breast Feeding  
Cold Sores (Oral Herpes)

Defibrillator  
Latex Allergy  
MRSA aka Resistant Staph Infection  
Pacemaker  
Requires antibiotic prior to surgical procedure  
Rapid heartbeat with epinephrine  
Pregnant or currently trying to get pregnant

Preferred Pharmacy: \_\_\_\_\_

Phone #: \_\_\_\_\_ City or Zip code: \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_ Clinic Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Referring Provider (if different from PCP): \_\_\_\_\_