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)

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

Other: ____

Past Surgical History: (please check all that apply)

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

Other: ____

Skin Disease History: (please check all that apply)

☐	Acne	☐	Cold Sores (oral herpes)	☐	Poison Ivy
☐	Actinic Keratosis	☐	Eczema	☐	Precancerous Moles
☐	Allergies / Hay Fever	☐	Flaking or Itchy Scalp	☐	Psoriasis
☐	Basal Cell Skin Cancer	☐	Genital Herpes	☐	Squamous Cell Skin Cancer
☐	Blistering Sunburns	☐	Melanoma	☐	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)

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____

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): ____