DERMATOLOGY ASSOCIATES OF PLYMOUTH MEETING, P.C.

Dermatology, Dermatologic Surgery, Mohs Surgery, Pathology

Current Medication	Dosage	Frequency	Current Medication	Dosage	Frequency

Allergies: (Please enter all allergies and associated reactions)

_____

_____

Social History: (**Please circle all that apply)**

Height_____ Weight_____

Currently smokes, **daily** Currently smokes, **not daily** **Never** smoked **Former** smoker

Do you have a Living Will? yes no

Alcohol:

Men: How many times in the past year have you had five (5) or more drinks in a day? _____

Women: How many times in the past year have you had four (4) or more drinks a day? _____

Drug Use: None _____ Other_____

Have you had a flu vaccine within the past year?__Yes ___ No **Have you had the pneumonia vaccine?** ___Yes ___No

		Yes	No
History of melanoma			
Pacemaker			
Defibrillator			
Artificial joints within past two years			
Artificial heart valve			
Premedication prior to procedures			
Allergy to adhesive			
Allergy to topical antibiotic ointments			
Blood thinners			
Pregnancy or planning a pregnancy			
Breastfeeding or lactation			
Allergy to lidocaine			
Rapid heart beat with epinephrine			
Problems with bleeding			
Problems with healing			
Problems with scarring (hypertrophic or keloid)			
Immunosuppression			

Pharmacy Name: _____

Pharmacy Telephone:_____ Fax: _____

Street _____City_____Zip Code

Referring Physician: _____

Telephone: _____ Fax:_____

Street _____City_____Zip Code

Family/Primary Physician: _____ Date of Last Visit:_____

Telephone_____Fax:_____

Street_____City_____Zip Code_____

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Intake Form

Patient: _____Phone Number: _____DOB:_____

State of Birth:_____Today's Date:_____

Reason for today's visit: _____

Current Medical History: (Please circle all that apply)

Anxiety	COPD	Hepatitis	Lymphoma
Arthritis	Coronary Artery Disease	High blood pressure	Pacemaker
Asthma	Depression	HIV/AIDS	Prostate Cancer
Atrial fibrillation	Diabetes	High cholesterol	Radiation Treatment
BPH	End Stage Renal Disease	Hyperthyroidism	Seizures
Bone Marrow Transplantation	GERD	Hypothyroidism	Stroke
Breast Cancer	Leukemia	Valve Replacement	
Colon Cancer	Hearing Loss	Lung Cancer	None

Other_____

Past Surgical History: (Please circle all that apply)

Appendix removed	Coronary Artery Bypass	Ovaries Removed Endometriosis
Bladder Removed	PTCA (Percutaneous transluminal coronary angioplasty	Ovaries Removed Cyst
Mastectomy (Right, Left, Bilateral)	Mechanical Valve Replacement	Ovaries Removed Ovarian Cancer
Lumpectomy (Right, Left, Bilateral)	Joint Replacement Knee, (Right, Left, Bilateral)	Prostate Removed Prostate Cancer
Breast Biopsy (Right, Left, Bilateral)l	Joint Replacement Hip (Right, Left, Bilateral)	Prostate Biopsy
Breast Reduction	Hysterectomy: Fibroids	TURP
Breast Implants	Hysterectomy: Uterine Cancer	Spleen Removed
Colectomy: Colon Cancer Resection	Kidney Biopsy	Testicles Removed
Colectomy: Diverticulitis	Kidney Removed (Right, Left)	(Right, Left, Bilateral)
Colectomy: IBS	Kidney Stone Removal	None
Gallbladder Removed	Kidney Transplant	

Other _____

Skin Disease History: (Please circle all that apply)

Acne	Eczema	Squamous Cell Skin Cancer
Actinic keratosis	Flaking or Itching Scalp	None
Basal Cell Carcinoma	Melanoma	Hay Fever/Allergies
Blistering Sunburns	Precancerous Moles	
Dry Skin	Psoriasis	

Other_____

Do **you** have a history of Melanoma? Yes No
Do you have a **family** history of Melanoma? Yes No
If so, which relative (s)?_____

Do you tan in a salon? Yes No

Do you wear Sunscreen: Yes No
If yes, what SPF? _____