Name_____
Date of birth_____
Date of Service_____

MOELLER
DERMATOLOGY

History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation (Irregular Heartbeat)
Bone Marrow Transplant
BPH
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
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
NONE
Other: _____

Past Surgical History: (please circle all that apply)

Appendix (Appendectomy)
Bladder (Cystectomy)
Breast: Breast Biopsy
Breast: Lumpectomy (Right, Left, Bilateral)
Breast: Mastectomy (Right, Left, Bilateral)
Colon (Colectomy): Colon Cancer Resection

(continues on reverse)

Colon (Colectomy): Diverticulitis
Colon (Colectomy): Inflammatory Bowel Disease
Colon: Colostomy
Gallbladder (Cholecystectomy)
Heart: Biological Valve Replacement
Heart: Coronary Artery Bypass Surgery
Heart: Heart Transplant
Heart: Mechanical Valve Replacement
Heart: PTCA
Joint Replacement: Hip (Right, Left, Bilateral)
Joint Replacement: Knee (Right, Left, Bilateral)
Kidney: Kidney Biopsy
Kidney: Kidney Stone Removal
Kidney: Kidney Transplant
Kidney: Nephrectomy
Liver: Hepatectomy
Liver: Liver Transplant
Liver: Shunt
Ovaries (Oophorectomy): Endometriosis
Ovaries (Oophorectomy): Ovarian Cancer
Ovaries (Oophorectomy): Ovarian Cyst
Ovaries: Tubal Ligation
Pancreas: Pancreatectomy
Prostate (Prostatectomy): Prostate Biopsy
Prostate (Prostatectomy): Prostate Cancer
Prostate (Prostatectomy): TURP
Rectum: APR
Rectum: Low Anterior Resection
Skin: Basal Cell Cancer Surgery
Skin: Melanoma
Skin: Skin Biopsy
Skin: Squamous Cell Carcinoma
Spleen (Splenectomy)
Testicles (Orchiectomy)
Uterus (Hysterectomy): Fibroids
Uterus (Hysterectomy): Uterine Cancer
Uterus (Hysterectomy): Cervical Cancer
NONE
Other: _____

Skin Disease History: (please circle all that apply)

Acne	Flaking or Itchy Scalp	**None**
Actinic Keratoses	Hay Fever/Allergies	
Asthma	Melanoma	
Basal Cell Skin Cancer	Poison Ivy	
Blistering Sunburns	Precancerous Moles	
Dry Skin	Psoriasis	
Eczema	Squamous Cell Skin Cancer	

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 enter all current prescriptions and over the counter medications including dosage)
_____
_____
_____

Allergies: (Please enter all allergies and reactions)
_____
_____
_____

Social History: (Please circle all that apply)
Smoking Status:
Current every day smoker
Current some day smoker (tobacco)
Current some day smoker (cigarette)
Former smoker
Has never smoked
Started smoking: _____packs per day: ____
Quit smoking: _____

Alcohol Use:
Do you drink alcohol? Yes No
If yes, how often: Occasionally Daily

Caffeine Use:
Several times a day
Once a day
Few times a week
Few times a month
Never

Exercise:
Several times a day
Once a day
Few times a week
Few times a month
Never
Occupation/Workplace: _____

(continues on reverse)

Place of residence: Home_____ School Housing_____ Assisted Living/Nursing_____ Other_____
Preferred Pharmacy: _____

_____

_____

Name_____
Date of birth_____
Date of Service_____

Review of Systems: Are you currently experiencing any of the following?
(Please check yes or no for the following)

Symptom	Yes	No
Abdominal Pain		
Allergies		
Anxiety		
Arthritis		
Bloody stool		
Bloody urine		
Blurry vision		
Cataracts		
Change in body hair		
Change in facial hair		
Chest pain		
Cough		
Depression		
Diarrhea		
Enlarged glands		
Excessive sweating		
Eyelid dermatitis		
Fatique		
Fever		
Flushing		
Hay fever		
Headaches		
Immunosuppression		
Lumps		
Mouth sores		
Muscle weakness		
Neck stiffness		
New medications		
Night sweats		
Problems with bleeding		

Problems with healing		
Problems with scarring		
Rash/sores/blisters		
Recent fever		
Recent surgery		
Seizures		
Shortness of breath		
Skin infections		
Sore joints		
Sore throat		
Stretch marks		
Sun sensitivity		
Thyroid problems		
Unintentional weight loss		
Vomiting		
Wheezing		

Alerts: Special instructions we may need to know.
(Please check yes or no for the following)

	Yes	**No**
Allergy to adhesive		
Allergy to lidocaine		
Allergy to topical antibiotic ointments		
Artificial heart valve		
Artificial joints within past two years		
Blood thinners		
Defibrillator		
MRSA		
Pacemaker		
Pregnant or planning a pregnancy		
Premedication prior to procedures		
Rapid heartbeat with epinephrine		

Other: _____

_____

_____

Skin Enhancement Center

Are you interested in discussing skincare products and/or cosmetic procedures that will improve the health and appearance of your skin? Yes No

If yes, what are your concerns? (Please circle all that apply)

Acne
Aging
Body sculpting
Dark spots
Dry skin
Redness
Scars
Skincare
Skin elasticity
Skin texture

(continues on reverse)

Excessive sweating
Hair reduction
Loss of facial volume
Stretch marks
Unwanted tattoo
Wrinkles