DERMATOLOGY ASSOCIATES OF PLYMOUTH MEETING, P.C.
Dermatology, Dermatologic Surgery, Mohs Surgery, Pathology

Medications: (Please enter all current medications)
____
____

Allergies: (Please enter all allergies and associated reactions)
____
____

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

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

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

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

	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

Primary Physician: ____
Telephone____Fax:_________________________________
Street_____________________________________City_______________________Zip Code__________

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Intake Form

Patient: ____**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	Hay Fever/Allergies	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	
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? _______________________