Porter Premiere Dermatology
& Surgery Center
New Patient History and Intake Form

Date: _____/_____/________

Patient Name: _________________________________ **Patient DOB:** _____/______/______

Patient Email Address: ____

Primary Care Physician: ___________________________ **PCP Phone #** _______________________

Date of last visit with PCP: ______/ _______/

Reason for your visit: ____

Race: _______________ White, American Indian, Asian, African American, Native Hawaiian, Other Race

Ethnicity:_______________ Hispanic/Latin, Not Hispanic/Latin, Unknown

Preferred Language: ________________ **Gender:** _________________ Male/Female

Past Medical History: (please circle all that apply)

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

Other ____

____

Past Surgical History: (please circle all that apply)

Appendix Removed	Colectomy: Diverticulitis
Bladder Removed	Colectomy: IBD
Mastectomy (Right, Left, Bilateral)	Gallbladder Removed
Lumpectomy (Right, Left, Bilateral)	Coronary Artery Bypass
Breast Biopsy (Right, Left, Bilateral)	PTCA
Breast Reduction	Mechanical Valve Replacement
Breast Implants	Biological Valve Replacement
Colectomy: Colon Cancer Resection	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
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
Other____
____

<u>Skin Disease History</u>: (please circle all that apply)

Acne
Actinic Keratosis
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
None
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)? ____
Any other family medical history: ____
____

<u>Medications</u>: (Please enter all current medications)

____
____
____
____
____

<u>Allergies</u>: (Please enter all allergies)

____
____
____

Social History: (Please circle all that apply)
Marital Status:
Unspecified
Married
Divorced
Single
Separated
Widowed
Other: ______________________________________

Cigarette Smoking:
Never smoked
Quit: former smoker
Smokes less than daily
Smokes daily

Sexual History:
Not sexually active
Sexually active with one partner
Sexually active with more than one partner
Same sex partner

Illicit Drug Use:
Drug Use
IV Drug Use

Alcohol Use:
Alcohol: none
Alcohol: less than 1 drink a day
Alcohol: 1-2 drinks a day
Alcohol: 3 or more drinks a day

Safety:
I feel safe at home.
I do not feel safe at home.

Did you receive the flu vaccine before this past flu season? Yes or No

Have you ever received the pneumonia vaccine? Yes or No

Do you have an Advance Care Plan (Living Will)? Yes or No

Pharmacy Information

Please list the name and location of the pharmacy where you do business

Pharmacy Name: ____

Pharmacy Location: ____

Pharmacy Telephone Number: ____

Alerts: Please indicate if the following Alerts apply to you. (check yes or no)

Alert	Yes	No
Pacemaker		
Defibrillator		
Artificial Joints within past two years		
Artificial heart valves		
Require premedication prior to procedures		
Allergy to adhesive		
Allergy to topical antibiotic ointments		
Blood thinners		
Currently pregnant or planning a pregnancy		
Allergy to lidocaine		
Allergy to marcaine		
Rapid heartbeat to epinephrine		
Yeast infections to antibiotics		
GI upset with antibiotics		

Other Alerts/Symptoms: ____

____

Emergency Contact Information

Name: ___________________________________ Relationship: _______________

Address: ____ ______

____

Phone: ___________________________________