Kay Bishop, M.D.

DERMATOLOGY
OF EASTERN IDAHO

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History and Intake Form

Name_____**Date**_____

Preferred Pharmacy_____ **Preferred Contact Method** _____

Past Medical History: (Please mark all that apply)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation (Irregular Heartbeat)
- ☐ BPH (Benign prostate hypertrophy)
- ☐ Bone Marrow Transplantation
- ☐ Breast Cancer – What Stage_____
- ☐ Colon Cancer – What Stage_____
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD (Gastroesophageal reflux disease)
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension (High blood pressure)
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia (High cholesterol)
- ☐ Hyperthyroidism (High thyroid)
- ☐ Hypothyroidism (Low thyroid)
- ☐ Leukemia
- ☐ Lung Cancer – What Stage_____
- ☐ Lymphoma
- ☐ Prostate Cancer – What Stage_____
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ NONE
- ☐ List Other_____

Past Surgical History: (Please mark all that apply)

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast:
  - ☐ Mastectomy ☐
  - ☐ Lumpectomy ☐
  - ☐ Breast Biopsy
  - ☐ Breast Reduction
  - ☐ Breast Implants
- ☐ Colon (Colectomy):
  - ☐ Colon Cancer Resection
  - ☐ Diverticulitis
  - ☐ Inflammatory Bowel Disease
- ☐ Colon: Colostomy
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Coronary Artery Bypass Surgery
  - ☐ PTCA (Percutaneous translurminal coronary angioplasty)
  - ☐ Mechanical Valve Replacement
  - ☐ Biological Valve Replacement
  - ☐ Heart Transplant
- ☐ Joint Replacement: Knee ☐
- ☐ Joint Replacement: Hip ☐
- ☐ Kidney:
  - ☐ Kidney Biopsy
  - ☐ Nephrectomy
  - ☐ Kidney Stone Removal
  - ☐ Kidney Transplant
- ☐ Liver: ☐Hepatectomy ☐Transplant ☐Shunt
- ☐ Oophorectomy (Ovaries) for Endometriosis
- ☐ Oophorectomy for Ovarian Cyst
- ☐ Oophorectomy for Ovarian Cancer
- ☐ Pancreas: Pancreatectomy
- ☐ Prostatectomy for Prostate Cancer
- ☐ Prostate Biopsy
- ☐ TURP (Transurethral resection of the prostate)
- ☐ Skin Biopsy
- ☐ Basal Cell Carcinoma
- ☐ Squamous Cell Carcinoma
- ☐ Melanoma
- ☐ Spleen (Splenectomy)
- ☐ Testicles (Orchiectomy)
- ☐ Hysterectomy due to Fibroids _____
- ☐ Hysterectomy due to Uterine Cancer _____
- ☐ Hysterectomy due to Cervical Cancer _____
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ List Other Surgeries_____

Skin Disease History: (Please mark 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)?_____

Medications: (Please enter all current medications, along with dosage) – Copies can be made

Allergies: (Please enter what type of reaction to allergen)

Social History: (please mark all that apply)

- ☐ Tobacco Use:
  - ☐ Never smoked
  - ☐ Quit: former smoker
  - ☐ Smokes less than daily
  - ☐ Smokes daily
  - ☐ Chewing Tobacco
- ☐ Alcohol Use:
  - ☐ None
  - ☐ Less than 1 drink a day
  - ☐ 1-2 drinks a day
  - ☐ 3 or more drinks a day

Alcohol Frequency: How many times in the past year have you had 5 (for men) or 4 (for women) or more drinks in a day?(circle one)

☐ 0 ☐ 1 ☐ 2 ☐ 3 or more

Vaccines: (circle one)

If you are 65 and older, have you received a pneumonia vaccine?

◯ **Yes** ◯ **No**

For all ages, have you received an influenza (flu) vaccine between the months of October to March?

◯ **Yes** ◯ **No**

If you are 13 and over, are you current on meningococcal vaccine, Tdap & pertussis vaccinations?

◯ **Yes** ◯ **No**

Other family medical history? (ex: diabetes, any type cancer, psoriasis & which family member)