DERMATOLOGY OF ATHENS

Main Address
2000 Prince Avenue
Athens, GA 30606

1220 Langford Drive
Bldg 100, Suite 103
Watkinsville, GA 30677

NAME: _____ **DATE OF BIRTH: _____**

History and Intake Form

Past Medical History: (Please CIRCLE all that apply)

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH (Enlarged Prostate)
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD (Emphysema)
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD (Acid reflux)
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia (High Cholesterol)
Hyperthyroidism (High Thyroid)
Hypothyroidism (Low Thyroid)
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke

None

Other _____

Past Surgical History: (Please CIRCLE all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Both)
Lumpectomy (Right, Left, Both)
Breast Biopsy (Right, Left, Both)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: Ulcerative colitis
Gallbladder Removed
Heart Surgery
Heart Angioplasty/Stents
Heart Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Both)
Joint Replacement, Hip (Right, Left, Both)
Joint Replacement within last 2 years
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
Skin Biopsy
Basal Cell Carcinoma Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Both)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer

None

Other _____

Date: _____

CONTINUED ON BACK

Skin Disease History: (Please CIRCLE all that apply)

Acne
Actinic Keratoses
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 family history of skin disease or skin cancer (basal cell or squamous cell):
_____

Medications: (Please list all current medications) **NONE**
_____
_____
_____

Allergies to Medications: (Please list) **NONE**
_____
_____

Social History: (Please CIRCLE one)

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

Alcohol Use:
YES
How much? _____
NO

Language:
English
Spanish
Other: _____

Race:
White
Black/African American
Asian
American Indian or Native Alaskan
Native Hawaiian/Pacific Islander

Ethnicity:
Hispanic/Latino
Non-Hispanic/Latino

Place of Birth
City _____
State _____
Zip Code _____
Country _____

Pharmacy: _____ **Location:** _____