GEORGIA SKIN CENTER
HISTORY & INTAKE FORM
(Please Print)

Patient: _____ Medical Record #:_____

How do you prefer that we address you (nickname, etc)? _____

Primary Care Physician: _____ Referring Physician: _____

Past Medical History/Alerts: (Please circle all that apply)

Alerts:
Blood Thinners
Defibrillator
Pre-meds Prior to Procedure
HIV/Hepatitis
Pregnant/Nursing

Allergic to:
Latex
Lidocaine
Epinephrine

Past Medical History:

Anxiety
Arthritis
Asthma
Atrial Fibrillation
BPH (prostate)
Bone Marrow Transplant
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD (reflux)
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyper **OR** Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
NONE
Other: _____
_____

Past Surgical History: (Please circle all that apply)

Appendix Removed
Bladder Removed

Breast:
Breast Biopsy
Lumpectomy (Right, Left, Bilateral)
Mastectomy (Right, Left Bilateral)

Colon:
Colectomy (Colon Cancer Resection)
Colectomy (Diverticulitis)
Colectomy (IBD)
Colostomy

Gallbladder Removed

Heart:
Biological Valve Replacement
Coronary Artery Bypass
Heart Transplant
Mechanical Valve Replacement
PTCA (Angioplasty)

Other: _____

Joint Replacement:
Hip (Right, Left, Bilateral)
Knee (Right, Left, Bilateral)

Kidney:
Kidney Biopsy
Kidney Stone Removal
Kidney Transplant
Nephrectomy (Kidney Removal)

Liver:
Hepatectomy (Liver Removal)
Liver Transplant
Shunt

Ovaries:
Oophorectomy (Endometriosis)
Oophorectomy (Ovarian Cancer)
Oophorectomy (Ovarian Cyst)
Tubal Ligation

Pancreas Removed

Other: _____

Prostate:
Prostatectomy (Biopsy)
Prostatectomy (Prostate Cancer)
Prostatectomy (TURP)

Rectum:
APR/Abdominoperineal Resection
Lower Anterior Resection

Skin:
Biopsy
Basal Cell Carcinoma
Squamous Cell Carcinoma
Melanoma

Spleen Removed
Testicles Removed

Uterus:
Hysterectomy (Fibroids)
Hysterectomy (Uterine Cancer)
Hysterectomy (Cervical Cancer)

NONE

Skin Disease History: (Please circle all that apply)

Acne
Actinic Keratosis
Basal Cell Carcinoma
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Rosacea
Squamous Cell Carcinoma
Other: _____

Do you wear sunscreen? YES NO What SPF? _____Do you tan in a tanning salon? YES NO

Do you have a family history of non-melanoma skin cancer? YES NO If yes, what relative(s)? _____

Do you have a family history of melanoma? YES NO If yes, what relative(s)? _____

Medications: (Please list all current medications)

1. _____ 4. _____ 7. _____

2. _____ 5. _____ 8. _____

3. _____ 6. _____ 9. _____

Immunizations: ***Flu Immunization*** - YES NO ***Pneumonia Vaccination*** - YES NO

ALLERGIES: (Please list all allergies and drug allergies as well as type of reaction)

_____

_____

***Pharmacy*:**

_____

Name Phone Street City State Zip Code

Height/Weight: _____

Do you have **health care proxy** in the event you are unable to make your own medical decisions? YES NO

Designee: _____ Designee Best Phone Number: _____

Do you have a **living will**? YES NO

Which statement best reflects your wishes on advanced care recommendations?

☐**Do Not Intubate**: I do not wish to have a breathing tube, even if it is necessary to save my life.

☐**Do Not Resuscitate**: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if its necessary to save my life.

☐**Full Cardiopulmonary Resuscitation**: I want full cardiopulmonary resuscitation efforts to be made.

Social History: (Please circle all that apply)

Tobacco: Current / Past / Never **Alcohol Consumption**: YES NO

How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a setting? _____

Do we have your permission to:

Leave a message on your answering machine at home? ☐YES ☐NO Cell phone? ☐YES ☐NO

Discuss your medical condition with any member of your household? ☐YES ☐NO

If yes, with whom: _____ Relationship: _____

All patients please sign:

- I authorize the release of any medical information needed to process Medicare and/or other insurance.
- I authorize Georgia Skin Center to treat the above named patient (including minors) as necessary.
- I authorize the release or acquisition of any medical information to/from any physician or physician's office, laboratory, pharmacy, hospital or surgical facility involved in my care. I have read the HIPAA privacy policy of Georgia Skin Center.

Signature: _____ Date:_____

Signature of Patient, Parent/Guardian or POA