HOUSTON DERMATOLOGY SPECIALISTS
Medical | Cosmetic | Mohs Surgery

Intake and History Form

Last Name: _______________________ First Name: __________________ Date: _______________

Street Address: _________________________________ City/State: __________________________

Zip Code: ______________________ Date of Birth: ___________________ Gender: _____________

Phone Number (day): _______________________ Phone Number (night): _____________________

Email Address: ___________________________________ Social Security #: ___________________

Emergency Contact: __________________________ Relationship: __________________________

Phone: _____________________________ Preferred Language: ______________________________

Race: ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian

☐ Native Hawaiian or Other Pacific Islander ☐ Other ___________________

Ethnic Group: ☐ Unspecified ☐ Declined to Specify ☐ Prohibited by State Law

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown.

Referring Physician: _______________________________ Phone: ___________________________

Primary Care Physician: _______________________________ Phone: ________________________

Insurance Information

Primary Insurance Holder Name: _________________________ Date of Birth: ________________

Address: ____

Insurance Name: _________________________ Insurance Phone Number: ____________________

Member ID: _________________ Group #: _________________

Relation to Patient: ____

Secondary or Supplemental Insurance: ____

Insurance Name: _________________________ Insurance Phone Number: ____________________

Member ID: _________________ Group #: _________________

Pharmacy Name: ____________________________ Phone Number: _________________________

Address: ____

"Failure to provide pharmacy information may result in a delay of prescriptions."

Medical History

Select any of the following medical conditions you currently have:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV / AIDS
- ☐ High Cholesterol
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Urinary Incontinence Daily (QM 48)
- ☐ Other
- ☐ _______________
- ☐ _______________

Surgical History

Have you had any surgeries on the following organs?

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast: Breast Biopsy
- ☐ Breast: Lumpectomy (Right, Left, Bilateral)
- ☐ Breast: Mastectomy (Right, Left, Bilateral)
- ☐ Colon (Colectomy): Colon Cancer Resection
- ☐ Colon (Colectomy): Diverticulitis
- ☐ Colon (Colectomy): Inflammatory Bowel Disease
- ☐ Colon (Colectomy): Colostomy
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Joint Replacement: Hip (Right, Left, Bilateral)
- ☐ Joint Replacement: Knee (Right, Left, Bilateral)
- ☐ Kidney: Kidney Biopsy
- ☐ Kidney: Kidney Stone Removal
- ☐ Kidney: Kidney Transplant
- ☐ Kidney: Nephrectomy
- ☐ Liver: Hepatectomy
- ☐ Liver: Liver Transplant
- ☐ Liver Shunt
- ☐ Ovaries (Oophorectomy): Endometriosis
- ☐ Ovaries (Oophorectomy): Ovarian Cancer
- ☐ Ovaries (Oophorectomy): Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate (Prostatectomy): TURP
- ☐ Prostate (Prostatectomy): APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Spleen (Splenectomy)
- ☐ Testicles (Orchiectomy)
- ☐ Uterus (Hysterectomy): Fibroids
- ☐ Uterus (Hysterectomy): Uterine Cancer
- ☐ Uterus (Hysterectomy): Cervical Cancer
- ☐ **NONE**
- ☐ Other
- ☐ ______________________
- ☐ ______________________

Skin Disease History

Have you had any of the following?

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Basal Cell Skin Cancer
- ☐ Blistering
- ☐ Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever / Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Squamous Cell Skin Cancer
- ☐ **NONE**
- ☐ Other
- ☐ ________________________
- ☐ ________________________

Do you use sunscreen?

☐ Yes ☐ No

If yes, what SPF? _____________________

Do you tan in a tanning salon?

☐ Yes ☐No

Do you have a family history of **Melanoma**? (QM 137)

☐ Yes ☐ No

If yes, which relative?

☐ Mother ☐ Uncle ☐ Grandson
☐ Father ☐ Aunt ☐ Granddaughter
☐ Sister ☐ Nephew ☐ Other
☐ Brother ☐ Niece ☐ ________________
☐ Daughter ☐ Grandmother ☐ ________________
☐ Son ☐ Grandfather

Medications (List all current medications)

____

____

Allergies to Medications (List all allergies and reactions, if known)

____

____

Smoking Status (please choose one) (QM 226)

☐ Current, Every Day Smoker
☐ Current, Some Day Smoker
☐ Former Smoker
☐ Never Smoker
☐ Unknown if Ever Smoked

Start Smoking (mm/dd/yyyy): ____________________
Quit Smoking (mm/dd/yyyy): ____________________
Total Years Smoking: ____________________________
Number of Packs Per Day: __________________

Alcohol Intake (please choose one)

☐ None
☐ 1 or less per day
☐ 1-2 per day
☐ 3 or more per day
☐ Other: _______________________

How often do you exercise?

☐ Once a day
☐ Several times a day
☐ A few times a week
☐ A few times a month
☐ Other: _______________________

What is your caffeine use?

☐ Unspecified
☐ Several times a day
☐ Once a day
☐ A few times a week
☐ A few times a month
☐ Never
☐ Other: _________________________

Advance Care (QM47)

Do you have a health care proxy in the event you are unable to make your own medical decisions?

☐ Yes ☐ No

If yes, name of proxy: ____

Phone number of proxy: ______________________________________