PIEDMONT PLASTIC SURGERY & DERMATOLOGY
www.ppsd.com

MR#

DATE

# HISTORY INTAKE FORM

***Please complete all questions. Be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice. An initial evaluation is required to determine whether you are a suitable candidate and whether the practice will accept you as a patient.***

Patient Name_____ Birth Date _____ Age_____

Height _____ Weight _____ Race_____ Preferred Language *(English, Spanish, etc.)* _____

Preferred Contact Method *(check one):* ☐ Home Phone_____ ☐ Cell_____ ☐ Email _____

Pharmacy Name and Address_____ Pharmacy Phone _____

Primary Care Doctor _____ City, State_____

Did a doctor refer you to our office? Yes/No If yes, whom? _____ City, State_____

**PAST MEDICAL HISTORY: Have you EVER had or currently have the following? ☐ No known past medical history.**

| CONDITION | | |
|---|---|---|
| Anxiety | Yes | No |
| Arthritis | Yes | No |
| Asthma | Yes | No |
| A Fib *(irregular heartbeat)* | Yes | No |
| BPH *(enlarged prostate)* | Yes | No |
| Bone Marrow Transplant | Yes | No |
| Breast Cancer | Yes | No |
| Colon Cancer | Yes | No |
| COPD | Yes | No |
| Coronary Artery Disease | Yes | No |

| CONDITION | | |
|---|---|---|
| Depression | Yes | No |
| Diabetes | Yes | No |
| Kidney Disease | Yes | No |
| Gastric Reflux (GERD) | Yes | No |
| Hearing Loss | Yes | No |
| Hepatitis | Yes | No |
| High Blood Pressure Controlled w/Medication | Yes | No |
| HIV/AIDS | Yes | No |
| High Cholesterol | Yes | No |

| CONDITION | | |
|---|---|---|
| Hyperthyroidism | Yes | No |
| Hypothyroidism | Yes | No |
| Leukemia | Yes | No |
| Lung Cancer | Yes | No |
| Lymphoma | Yes | No |
| Prostate Cancer | Yes | No |
| Radiation Treatment | Yes | No |
| Seizures | Yes | No |
| Stroke | Yes | No |
| **Other:** | | No |

**PAST SURGICAL HISTORY: Have you EVER had the following? ☐ No surgeries.**

| | | |
|---|---|---|
| ☐ Appendix Removal *(Appendectomy)* | ☐ Heart: Heart Transplant | ☐ Ovaries: Ovarian Cyst |
| ☐ Bladder Removal *(Cystectomy)* | ☐ Heart: Mechanical Valve Replacement | ☐ Ovaries: Tubal Ligation |
| ☐ Breast: Biopsy | ☐ Heart: Attack/Stents *(PTCA )* | ☐ Prostate: Biopsy |
| ☐ Breast: Lumpectomy ☐Left ☐Right ☐Both | ☐ Joint Replacement: Hip ☐ Left ☐ Right ☐Both | ☐ Prostate: Cancer |
| ☐ Breast: Mastectomy ☐Left ☐Right ☐Both | ☐ Joint Replacement: Knee ☐ Left ☐ Right ☐ Both | ☐ Prostate Removal *(Prostatectomy)* |
| ☐ Colon: Colectomy | ☐ Kidney: Biopsy | ☐ Prostate: TURP |
| ☐ Colon Cancer | ☐ Kidney: Stone(s) Removal | ☐ Skin Biopsy |
| ☐ Colon: Diverticulitis | ☐ Kidney: Transplant | ☐ Spleen Removal *(Splenectomy)* |
| ☐ Colon: IBS/IBD | ☐ Kidney: Removal *(Nephrectomy)* | ☐ Testicle(s) Removal *(Orchiectomy)* |
| ☐ Gallbladder *(Cholecystectomy)* | ☐ Ovaries: Ovary Removal *(Oophorectomy)* | ☐ Uterus: (Hysterectomy) Fibroids |
| ☐ Heart: Biological Valve Replacement | ☐ Ovaries: Endometriosis | ☐ Uterus: (Hysterectomy) Uterine Cancer |
| ☐ Heart: Bypass Surgery | ☐ Ovaries: Ovarian Cancer | ☐ Uterus: (Hysterectomy) Cervical Cancer |
| ☐ **Other:** | | |

**SKIN HISTORY: Have you EVER had or currently have the following? ☐ No skin condition history.**

| | | |
|---|---|---|
| ☐ Acne | ☐ Eczema | ☐ Precancerous Moles |
| ☐ Actinic Keratoses *(Pre-cancers)* | ☐ Flaking or Itchy Scalp | ☐ Psoriasis |
| ☐ Basal Cell Carcinoma | ☐ Hay Fever/Allergies | ☐ Squamous Cell Carcinoma |
| ☐ Blistering Sunburns | ☐ Melanoma | ☐ **Other:** |
| ☐ Dry Skin | ☐ Poison Ivy | |

**SKIN CANCER HISTORY: List any prior skin cancers. ☐ No skin cancer history.**

| Diagnosis | Body Location | Treatment Date | Treatment Method *(example: excision)* |
|---|---|---|---|
| | | | |
| | | | |

Do you wear sunscreen? ☐ Yes ☐ No If yes, what SPF? _____ Do you go to tanning salons? ☐ Yes ☐ No

Do you have a family history of melanoma? ☐ Yes ☐ No If yes, which relative(s)? _____

FORM CONTINUES ON BACK

**PAST PLASTIC SURGICAL HISTORY: Have you EVER had the following? ☐ No surgeries.**

| | | |
|---|---|---|
| ☐ Abdomen: Abdominoplasty *(Tummy Tuck)* | ☐ Breast: Augmentation *(Implants)* | ☐ **Other:** |
| ☐ Body Contouring: Liposuction | ☐ Breast: Reduction | |

**Malignant Hyperthermia and Anesthesia History**

Do you have a family history of malignant hyperthermia or severe reaction to anesthesia? ☐ Yes ☐ No

If you have a family history, which relative(s)? _____

**MEDICATIONS: ☐ No known medications.**

**List ALL prescriptions, over-the-counter, herbal, and/or vitamin(s). Complete medication name, strength, dose, route, and frequency.**

| Medication Name | Strength *(example: 100 mg)* | Dose *(example: one pill)* | Route *(example: by mouth)* | Frequency *(example: once a day)* |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**ALLERGIES: List your allergies and reaction. ☐ No known allergies.**

| Medication or Allergen | Reaction *(examples: rash, nausea, GI upset)* |
|---|---|
| | |
| | |

**SOCIAL HISTORY: Answer with the best response.**

Current Smoking/Tobacco Use Status? ☐ Every day ☐ Some days ☐ Former ☐ Never

Alcohol Usage: ☐ None Less ☐ than 1 drink per day ☐ 1-2 drinks per day ☐ 3 or more drinks per day

FOR MEN: How many times in the past year have you had 5 or more drinks in a day? _____

FOR WOMEN: How many times in the past year have you had 4 or more drinks in a day? _____

**FAMILY MEDICAL HISTORY: List major medical conditions of first-degree relatives.**

Father _____

Mother _____

Brother(s) _____ Sister(s) _____

**REVIEW OF SYSTEMS: Have you had any of the following in the past year? ☐ No symptoms.**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Abdominal Pain | Yes | No | Easy Bleeding or Bruising | Yes | No | Night Sweats | Yes | No |
| Anxiety | Yes | No | Fevers or Chills | Yes | No | Problems with Scarring (keloids) | Yes | No |
| Bloody Stool | Yes | No | Hair Loss | Yes | No | Rash | Yes | No |
| Bloody Urine | Yes | No | Hay Fever | Yes | No | Seizures | Yes | No |
| Chest Pain | Yes | No | Headaches | Yes | No | Sensitivity to Light or Sunburn Easily | Yes | No |
| Cough | Yes | No | Immunosuppression | Yes | No | Shortness of Breath | Yes | No |
| Depression or Sad Mood | Yes | No | Joint Aches | Yes | No | Sore Throat | Yes | No |
| Diarrhea | Yes | No | Mouth Ulcers | Yes | No | Thyroid Problems | Yes | No |
| Difficulty Healing Wounds | Yes | No | Muscle Weakness | Yes | No | Unintentional Weight Loss | Yes | No |
| Dry Eyes | Yes | No | Neck Stiffness | Yes | No | Vision Changes or Blurred Vision | Yes | No |
| **Other:** | | | | | | | | |

**ALERTS: Answer the following important questions.**

| | | | | | |
|---|---|---|---|---|---|
| Allergy to adhesives or tape? | Yes | No | Defibrillator? | Yes | No |
| Allergy to numbing medicines? | Yes | No | History of MRSA infection(s)? | Yes | No |
| Allergy to topical antibiotic creams or ointments? | Yes | No | History of Melanoma? | Yes | No |
| Allergy to latex? | Yes | No | Pacemaker? | Yes | No |
| Artificial heart valve? | Yes | No | Require antibiotic prior to procedures? | Yes | No |
| Joint replacement(s) in last 2 years? | Yes | No | Rapid heartbeat with numbing medicines? | Yes | No |
| Blood thinners? | Yes | No | Pregnant or planning to become pregnant? | Yes | No |

**VACCINATION:** Did you receive your **Influenza Flu vaccination**? ☐ Yes ☐ No

**For pts 65 and older:** Have you received a **Pneumonia vaccination**? ☐ Yes ☐ No

**ADVANCE CARE (For all pts. 65 and older):**

Do you have a **Health Care Proxy** in the event you are unable to make your own decisions? ☐ Yes ☐ No

Do you have a **Living Will?** ☐ Yes ☐ No