

# History Intake Form

## Health History: Piedmont Plastic Surgery & Dermatology

**Patient Name:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_

**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **Race** \_\_\_\_\_ **Sex** \_\_\_\_\_

Please answer all of the questions as accurately as possible.

**Reason for visit:** \_\_\_\_\_

**Primary Care Doctor:** \_\_\_\_\_

**Drug Allergies:** \_\_\_\_\_

**Temperature** \_\_\_\_\_ **Blood Pressure** \_\_\_\_\_ **Pulse** \_\_\_\_\_ **Respirations** \_\_\_\_\_

**Past Medical History:** Have you ever had the following:

AIDS/HIV	Yes	No	Easy Bleeding/Bruising	Yes	No	Kidney Disease	Yes	No
Anemia	Yes	No	GI/Bowel Disease	Yes	No	Mitral Valve Prolapse	Yes	No
Arthritis	Yes	No	Glaucoma	Yes	No	Rheumatic Fever	Yes	No
Asthma	Yes	No	Heart Disease/Attack	Yes	No	Stomach Ulcer	Yes	No
Breast Disease	Yes	No	Hepatitis	Yes	No	Stroke	Yes	No
Cancer	Yes	No	High Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Diabetes	Yes	No	High Cholesterol	Yes	No	Tuberculosis	Yes	No

**List previous surgeries or major illnesses and dates:** \_\_\_\_\_

**List any medications you are taking, including non-prescription drugs, vitamins, and herbals:** \_\_\_\_\_

**Circle if you have a Pacemaker/AICD, Prosthesis, Artificial Heart Valve, or Joint Replacement.**

**Have you ever had Skin Cancer? (If yes, list type, date, and location):** \_\_\_\_\_

**Review of Systems:** Circle any of the following you have had in the past year:

Blood in urine/stool	Chronic pain	Irregular heartbeat	Seizures
Blurry vision	Depression	Jaundice	Severe sunburns
Chest pain	Dry eyes	Joint pain	Swollen feet/ankles
Chronic cough	Easy bruising/bleeding	Migraines	Weight gain/loss
Chronic diarrhea	Heartburn	Mouth sores	Yeast infections

**Family History:** Has any blood relative ever had the following:

Breast Cancer	Yes	No	Heart Disease	Yes	No	Melanoma	Yes	No
Depression	Yes	No	High Blood Pressure	Yes	No	Skin Cancer	Yes	No
Diabetes	Yes	No	Kidney Disease	Yes	No	Stroke	Yes	No

**Social History:**

Do you use tobacco? (Type & Amount Per Day) \_\_\_\_\_ Date quit: \_\_\_\_\_

Do you drink alcohol (Type & Amount Per Week) \_\_\_\_\_

Do you use a tanning bed? (How often) \_\_\_\_\_

**Women Only:**

Age period began \_\_\_\_\_ Number of pregnancies \_\_\_\_\_ Date of last pregnancy \_\_\_\_\_

Date of last mammogram \_\_\_\_\_ Did you breast feed:  Yes  No

Do you do regular breast self examinations:  Yes  No Breast lump or discharge  Yes  No

**I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.**

X \_\_\_\_\_ Date

Signature of patient or parent if minor

**Provider Initials** \_\_\_\_\_

**Clinical Staff Initials** \_\_\_\_\_