MIAMI
DERMATOLOGY
& MOHS SURGERY

HEALTH INTAKE

Last Name: _____ First Name: _____ M.I.: ____ Today's Date: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Occupation: _____ Employer: _____

PAST MEDICAL HISTORY

- ☐ Alzheimers
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ Benign Prostatic Hyperplasia
- ☐ Cancer/Malignancy: _____
- ☐ COPD/Emphysema
- ☐ Coronary Artery Disease/Heart
- ☐ Disease COVID-19
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease/Dialysis
- ☐ GERD (Acid Reflux)
- ☐ Hearing Loss
- ☐ Heart Valve Replacement
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Hypertension/High Blood Pressure
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Lymphoma
- ☐ Radiation Therapy
- ☐ Seizures
- ☐ Seasonal Allergies
- ☐ Stroke
- ☐ Transplant: _____
- ☐ Other _____

_____

PAST SURGICAL HISTORY

_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____

SKIN DISEASE HISTORY

- ☐ Acne
- ☐ Atopic Dermatitis
- ☐ Blistering Sunburns: How Many? _____
- ☐ Eczema
- ☐ Herpes: ☐ Oral ☐ Genital
- ☐ Hidradenitis Suppurativa
- ☐ Keloid
- ☐ Melasma
- ☐ Psoriasis
- ☐ Vitiligo
- ☐ Other: _____

SKIN CANCER/PRECANCER HISTORY

- ☐ Actinic Keratosis: Past Treatments ☐ Chemo Cream/Fluorouracil ☐ Blue light (PDT) ☐ Liquid nitrogen
- ☐ Atypical/Dysplastic/Precancerous Moles ☐ Treated ☐ Untreated When: _____
- ☐ Basal Cell: ☐ Treated ☐ Untreated When: _____
- ☐ Squamous Cell: ☐ Treated ☐ Untreated When: _____

MIAMI
DERMATOLOGY
& MOHS SURGERY

HEALTH INTAKE

☐ Melanoma: ☐ Treated ☐ Untreated When: _____
☐ Other: _____ ☐ Treated ☐ Untreated When: _____

Do you have a family history of melanoma? ☐ Y ☐ N If so, who? _____
Do you wear suncreen? ☐ Y ☐ N If so, how often? _____ Number of years? _____
Do/did you tan in a tanning salon? ☐ Y ☐ N If so, how often? _____ What age did you start/end? _____
Do/did you tan outdoors? ☐ Y ☐ N If so, how often? _____ What age did you start/end? _____

MEDICATIONS ☐ None

Including Over The Counter and Herbal Supplements

_____ _____
_____ _____
_____ _____
_____ _____

ALLERGIES ☐ None

_____ _____
_____ _____

SOCIAL HISTORY

Cigarette Smoker: ☐ Never ☐ Former ☐ Every day ☐ Some days
Alcohol: ☐ None ☐ Active Drinker (>1 drink/day) ☐ Social Drinker (<4 drinks/week)

REVIEW OF SYSTEMS

Do you currently have problems with the following?

☐ Bleeding ☐ Fatigue ☐ Immunosuppresed ☐ Numbness/Tingling
☐ Blurry Vision ☐ Fevers/Chills ☐ Joint Pain ☐ Shortness of Breath
☐ Chest Pain ☐ Headaches ☐ Night Sweats ☐ Unintentional Weight Loss

ALERTS

Do you have any of the following?

☐ Pregnancy ☐ Trying To Conceive ☐ Breastfeeding
☐ Pacemaker
☐ Defibrillator
☐ Joint Replacement within the Past Two Years
☐ Artificial Heart Valve
☐ Premedication Prior to Procedures
☐ Blood Thinners
☐ Bleeding Disorder
☐ Endocarditis History
☐ History of Organ Transplant: _____
☐ Allergy to Adhesive
☐ Allergy To Latex
☐ Allergy to Topical Ointments
☐ Allergy to Lidocaine/Anesthesia
☐ Rapid Heart Beat with Epinephrine
☐ Prone to Keloids/Scarring
☐ MRSA History
☐ Immunocompromised
☐ Fainting Before Procedures
☐ Born with a Heart Condition: _____

REASON FOR YOUR VISIT

_____
_____
_____