HOUSTON DERMATOLOGY SPECIALISTS
Medical | Cosmetic | Mohs Surgery

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Board-Certified Mohs Surgeon and Dermatologist

Intake and History Form

Last Name: _____ First Name: _____ Date: _____

Street Address: _____ City/State: _____

Zip Code: _____ Date of Birth: _____ Gender: _____

Phone Number (cell): _____ Phone Number (home): _____

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 ☐ Hispanic or Latino ☐ Not Hispanic or Latino

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: _____

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
- ☐ Hypertension
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ **NONE**
- ☐ 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**?

☐ 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)

☐ 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

Have you had your influenza vaccination within the last year? ☐ Yes ☐ No

Have you had your pneumonia vaccination? ☐ Yes ☐ No