Dermatology Partners of Northern New Mexico, LLC
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History and Intake Form

Name: DOB: Age

Who is you Primary Care Provider: ______________________________
Do you have a health care provider referral: Yes No
Who referred you: Self Other
Reason for visit today? ______________________________
Can we leave a voicemail with Result details? Yes No
Phone Number: ______________________________
Email: ______________________________

Past Medical History: (please check all that apply)

None

Anxiety	Depression	Thyroid Problems
Arthritis	Diabetes	Hyper Hypo
Asthma	End Stage Renal Disease	Leukemia
Atrial Fibrillation	GERD	Lung Cancer
Bone Marrow Transplant	Hearing Loss	Lymphoma
Breast Cancer	Hepatitis	Prostate Cancer
Colon Cancer	High Blood Pressure	Radiation Treatment
COPD	High Cholesterol	Seizures
Coronary Artery Disease	HIV/AIDS	Stroke

Other: ______________________________

Past Surgical History (please check all that apply)

None	
Appendix Removed	Joint replacement, Knee (right, left, bilateral)
Bladder Removed	
Mastectomy (right, left, bilateral)	Joint replacement, Hip (right, left, bilateral)
Lumpectomy (right, left, bilateral)	
Breast Biopsy (right, left, bilateral)	Joint replacement within last 2 years
Breast Reduction	Kidney Biopsy (Nephrectomy)
Breast Implants	Kidney Removed (right, left)
Colectomy: Colon Cancer Resection	Kidney Stone Removal
Colectomy: Diverticulitis	Ovaries Remove Endometriosis
Colectomy: IBD	Ovaries Removed Cyst
Gallbladder Removed	Ovaries Removed Ovarian Cancer
Coronary Artery Bypass	Prostate Removed Prostate Cancer
Mechanical Valve Replacement	Prostate Biopsy
Biological Valve Replacement	TURP (Prostate Removed)
Heart Replacement	Spleen Removed
Hysterectomy Uterine	Testicles Removed (Right, Left, Bilateral)
Hysterectomy Fibroids	

OTHER ______________________________

Skin Disease History (please check all that apply)
None

Acne	Dry Skin	Poison Ivy
Actinic Keratosis	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Carcinoma	Hay Fever/Allergies	Squamous Cell Carcinoma
Blistering Sunburns	Melanoma	Rosacea

Other: ____

Family History of Non-Melanoma Skin Cancer
Family History of Melanoma

Do you use sunscreen?	Yes	No	If yes, what SPF? ____________________
Do you tan in a tanning salon?	Yes	No	

Medications and or Supplements: none

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Drug Allergies: None
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____
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Social History: (please check all that apply)

Cigarette Smoking:

Currently Smokes, packs per day______
Have Smoke in the Past
Never Smoked

Alcohol Use:

None
Less than 1 drink per day
1-2 drinks per day
3 or more drinks per day

Other Medical Family History (Only First-Degree Relatives):

____

Your Occupation: ____

Preferred Language: ____

Race: ______________________________. Ethnic Group: ______________________________

What Pharmacy Do You Use: ____

Street/City/State?: ____

Please Check any of the following that apply

- Problems with bleeding
- Problems with healing
- Problems with scarring
- Rash
- Immunosuppression
- Hay Fever
- Chest pain
- Fever or chills
- Night Sweats
- Unintentional Weight Loss
- Thyroid Problems
- Sore throat
- Blurry vision
- Abdominal pain
- Bloody stool
- Bloody urine
- Joint aches
- Muscle weakness
- Neck stiffness
- Headaches
- Seizures
- Cough
- Shortness of breath
- Wheezing
- Anxiety
- Depression

- Allergy to adhesive
- Allergy to lidocaine
- Allergy to topical antibiotic ointments
- Artificial joints within past two years
- Blood Thinners
- Defibrillator
- MRSA
- Pacemaker
- Premedication to procedures
- Rapid heartbeat with epinephrine
- Pregnancy or planning a pregnancy
- Prostate Removed Prostate Cancer

Other: ____

Are you interested in any cosmetic procedures?

- Dermapen
- Botox
- Fillers

Other: ____

If you are interested in any product or cosmetic promotions, please leave us your email address

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