

# DERMATOLOGY OF ATHENS

**Main Address**  
2000 Prince Avenue  
Athens, GA 30606

1220 Langford Drive  
Bldg 100, Suite 103  
Watkinsville, GA 30677

**NAME:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_

## History and Intake Form

**Past Medical History:** (Please CIRCLE all that apply)

Anxiety	Hepatitis
Arthritis	Hypertension
Artificial joints	HIV/AIDS
Asthma	Hypercholesterolemia (High Cholesterol)
Atrial fibrillation	Hyperthyroidism (High Thyroid)
BPH (Enlarged Prostate)	Hypothyroidism (Low Thyroid)
Bone Marrow Transplantation	Leukemia
Breast Cancer	Lung Cancer
Colon Cancer	Lymphoma
COPD (Emphysema)	Pacemaker
Coronary Artery Disease	Prostate Cancer
Depression	Radiation Treatment
Diabetes	Seizures
End Stage Renal Disease	Stroke
GERD (Acid reflux)	
Hearing Loss	<b>None</b>
Other _____	

**Past Surgical History:** (Please CIRCLE all that apply)

Appendix Removed	Kidney Biopsy
Bladder Removed	Kidney Removed (Right, Left)
Mastectomy (Right, Left, Both)	Kidney Stone Removal
Lumpectomy (Right, Left, Both)	Kidney Transplant
Breast Biopsy (Right, Left, Both)	Ovaries Removed: Endometriosis
Breast Reduction	Ovaries Removed: Cyst
Breast Implants	Ovaries Removed: Ovarian Cancer
Colectomy: Colon Cancer Resection	Prostate Removed: Prostate Cancer
Colectomy: Diverticulitis	Prostate Biopsy
Colectomy: Ulcerative colitis	TURP
Gallbladder Removed	Skin Biopsy
Heart Surgery	Basal Cell Carcinoma Surgery
Heart Angioplasty/Stents	Squamous Cell Carcinoma Surgery
Heart Valve Replacement	Melanoma Surgery
Heart Transplant	Spleen Removed
Joint Replacement, Knee (Right, Left, Both)	Testicles Removed (Right, Left, Both)
Joint Replacement, Hip (Right, Left, Both)	Hysterectomy: Fibroids
Joint Replacement within last 2 years	Hysterectomy: Uterine Cancer
	<b>None</b>

Other \_\_\_\_\_

Date: \_\_\_\_\_

**CONTINUED ON BACK**

**Skin Disease History:** (Please CIRCLE all that apply)

Acne	Melanoma
Actinic Keratoses	Poison Ivy
Basal Cell Skin Cancer	Precancerous Moles
Blistering Sunburns	Psoriasis
Dry Skin	Squamous Cell Skin Cancer
Eczema	
Flaking or Itchy Scalp	<b>None</b>
Hay Fever/Allergies	
Other _____	

Do you wear 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(s)? \_\_\_\_\_

Any family history of skin disease or skin cancer (basal cell or squamous cell):

**Medications:** (Please list all current medications)                      **NONE**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies to Medications:** (Please list)                                      **NONE**

\_\_\_\_\_  
\_\_\_\_\_

**Social History:** (Please CIRCLE one)

**Cigarette Smoking:**

Never smoked  
Quit: former smoker  
Smoke less than daily  
Smoke daily

**Alcohol Use:**

YES  
How much? \_\_\_\_\_  
NO

**Language:**

English  
Spanish  
Other: \_\_\_\_\_

**Race:**

White  
Black/African American  
Asian  
American Indian or Native Alaskan  
Native Hawaiian/Pacific Islander

**Ethnicity:**

Hispanic/Latino  
Non-Hispanic/Latino

**Place of Birth**

City \_\_\_\_\_  
State \_\_\_\_\_  
Zip Code \_\_\_\_\_  
Country \_\_\_\_\_

**Pharmacy:** \_\_\_\_\_ **Location:** \_\_\_\_\_