OASIS
DERMATOLOGY

History and Intake Form

Name: _____ Date of Birth:_____ Today's Date:_____

Past Medical History (please select all that apply)

- ☐ None
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Benign prostatic hyperplasia
- ☐ Cerebrovascular accident
- ☐ Chronic obstructive lung disease
- ☐ Coronary arthritis
- ☐ Depressive disorder
- ☐ Diabetes mellitus
- ☐ H/O COVID-19
- ☐ Elevated blood pressure
- ☐ End-stage renal disease
- ☐ Epilepsy
- ☐ Gastroesophageal reflux disease
- ☐ Hypertension
- ☐ Hearing loss
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Inflammatory disease of liver
- ☐ Leukemia
- ☐ Malignant lymphoma
- ☐ Malignant tumor of breast
- ☐ Malignant tumor of colon
- ☐ Malignant tumor of lung
- ☐ Malignant tumor of prostate
- ☐ Radiation therapy treatment management
- ☐ Transplantation of bone marrow
- ☐ Other: _____ _____

Past Surgical History (please select all that apply)

- ☐ None
- ☐ Bilateral replacement of knee joints
- ☐ Coronary artery bypass graft
- ☐ Entire transplanted kidney
- ☐ Excision of basal cell carcinoma
- ☐ Excision of melanoma
- ☐ Excision of squamous cell carcinoma
- ☐ History of bilateral mastectomy
- ☐ History of colectomy
- ☐ Mastectomy of left breast
- ☐ Mastectomy of right breast
- ☐ Mechanical heart valve replacement
- ☐ Prostatectomy
- ☐ Total nephrectomy
- ☐ Total replacement of left hip joint
- ☐ Total replacement of left knee joint
- ☐ Total replacement of right hip joint
- ☐ Total replacement of right knee joint
- ☐ Transplantation of heart
- ☐ Transplantation of liver
- ☐ Other: _____ _____

Skin Disease History (please select all that apply)

- ☐ None
- ☐ Acne
- ☐ Actinic keratosis
- ☐ Basal cell carcinoma of skin
- ☐ Contact dermatitis due to poison ivy
- ☐ Dysplastic nevus of skin
- ☐ Eczema
- ☐ H/O: asthma
- ☐ H/O: hay fever
- ☐ Malignant melanoma
- ☐ Pruritus of scalp
- ☐ Psoriasis
- ☐ Squamous cell carcinoma
- ☐ Sunburn of second degree
- ☐ Other: _____ _____

Do you wear sunscreen? ◯ Yes ◯ No

If yes, what SPF? _____

Tan in a tanning salon? ◯ Yes ◯ No

Family history of Melanoma? ◯ Yes ◯ No
If yes, which relative(s)? _____

Cigarette smoking? ◯ Never smoked ◯ Former smoker ◯ Smoke less than daily ◯ Smoke daily

Smokeless tobacco? ◯ Yes ◯ No

Alcohol?: ◯ Yes ◯ No If yes how many drinks a day? ◯ < 1 ◯ 1-2 ◯ > 3

Medications (include herbals and supplements):

Name	Dose (amount of medication taken)	Frequency (how often medication is taken)

Allergies:

Occupation _____ Retired? Yes or No

Did you get a flu shot? Y/N If over 65: Pneumonia vaccination? Y/N Have you received a Covid vaccination? Y/N

Do you have a living will? Y/N

ALERTS: (please select all that apply)

- ☐ Allergy to adhesive
- ☐ Allergy to lidocaine
- ☐ Allergy to topical antibiotics
- ☐ Artificial heart valve
- ☐ Artificial joint replacement within the past 2 years
- ☐ Blood thinners such as aspirin, vitamin E, or Coumadin?
- ☐ Defibrillator
- ☐ Immunosuppression
- ☐ MRSA
- ☐ Organ Transplant
- ☐ Pacemaker
- ☐ Require antibiotics prior to a surgical procedure
- ☐ Rapid heart beat with epinephrine
- ☐ Are you pregnant or currently trying to get pregnant?

Contact Information:

Preferred contact method: ◯ email ◯ phone ◯ text

Pharmacy: _____ Cross streets:_____

Email address: _____

Is it Ok to leave a detailed message? ◯ yes ◯ no