Mercer Island
DERMATOLOGY
Allison Hughes MD, PhD

Patient Name: _____ DOB: _____

History and Intake Form

Past Medical History: *(please circle all that apply)*

☐ **NONE**

Arthritis
Asthma
Bone marrow transplant
Chronic obstructive lung disease
Coronary arteriosclerosis
Depressive disorder
Diabetes mellitus
Disease caused by 2019-Covid
End-stage renal disease
History of hypertension
Hepatitis
HIV
High Cholesterol
Hyperthyroidism
Hypothyroidism
Leukemia
Malignant lymphoma
Malignant tumor of:
☐ Lung
☐ Breast
☐ Colon
☐ Prostate

Past Surgical History: *(please circle all that apply)*

☐ **NONE**

Excision of:
☐ Basal cell carcinoma
☐ Melanoma
☐ Squamous cell carcinoma
History of tubal ligation
Heart transplant
History of appendectomy
History of cholecystectomy
History of colectomy
History of left hip replacement
History of right hip replacement
History of left knee replacement
History of right knee replacement
History of transurethral prostatectomy
Hysterectomy
Kidney transplant recipient
Mastectomy
Mechanical heart valve replacement
Prostatectomy
Transplantation of the heart
Transplantation of the liver
Vasectomy
Kidney Transplant
Other: _____
_____

Skin Disease History: *(please circle all that apply)*

☐ **NONE**

Acne
Actinic keratosis
Alopecia
Basal cell carcinoma of skin
Contact dermatitis
Disorder or nail
Dysplastic nevus
Eczema
History of asthma
History of hay fever
Other:_____
Itching
Itching of scalp
Malignant melanoma
Molluscum contagiosum
Psoriasis
Rosacea
Seborrheic dermatitis
Squamous cell carcinoma
Sunburn of second degree
Wart

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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)? _____

Medications: *(Please enter all current medications-include dosages and supplement names)*
☐ **Check here if you consent for us to import your RX history** ☐ **NONE**

_____
_____
_____
_____

Drug Allergies: *(Please enter all allergies and **reactions**)* ☐ **NONE**

_____
_____

REVIEW OF SYMPTOMS:
☐ **NONE**
*(Please circle all that apply **today**)*
Problems with Bleeding
Problems with Healing
Problems with Scarring
Fevers or Chills
Hay Fever
Thyroid Problems
Sore Throat
Blurry Vision
Abdominal Pain
Joint Aches
Immunosuppression
Headache
Shortness of Breath
Depression

ALERTS: ☐ **NONE**
(Please circle all that apply)
Are you pregnant or currently trying to get pregnant?
Are you currently breastfeeding?
Allergy to Adhesive
Allergy to Lidocaine
Allergy to topical antibiotics
Allergy to Latex
Artificial Heart Valve
Artificial Joint within the past 2 years
Blood thinners
Defibrillator
Easy Fainting/Vasovagal
Fast metabolizer of Lidocaine
MRSA
Pacemaker
Require antibiotics prior to a surgical procedure
Rapid Heartbeat with Epinephrine
HIV/ Hepatitis B or C
Personal History of Melanoma

Family History: Do any of your immediate family members have any of the following conditions?
Immediate family is defined as a close blood relative which includes parents, full siblings, or children

Medical Condition:
☐ Asthma
☐ Congenital Heart disease
☐ Diabetes
☐ Migraines
☐ Stroke
☐ Psoriasis
☐ **NONE**

Please tell us which family member:
_____
_____
_____
_____
_____
_____