PINNACLE DERMATOLOGY
medical | surgical | cosmetic
A Division of Prime Medical Group, PLLC

Patient Medical History Intake Form

Today's Date: _____

Patient Name	**Date of Birth**

Reason for Today's Visit	
Primary Care Provider	Referring Physician (if applicable)
Preferred Pharmacy	Pharmacy Address and Phone Number

Do you authorize us to upload your prescriptions from your pharmacy? ☐ Yes ☐ No

Medical History (please check any conditions you are currently being treated for or have had in the past) ☐ None

☐	Anxiety Disorder	☐	Depressive Disorder	☐	History of Radiation Therapy	☐	Malignant Lymphoma
☐	Arthritis	☐	Diabetes Mellitus	☐	HIV	☐	Malignant Tumor of Breast
☐	Asthma	☐	Elevated Blood Pressure	☐	Hypercholesterolemia (High Cholesterol)	☐	Malignant Tumor of Colon
☐	Atrial Fibrillation	☐	End-Stage Renal Disease	☐	Hyperthyroidism	☐	Malignant Tumor of Prostate
☐	Cerebrovascular Accident (Stroke)	☐	Epilepsy (Seizures)	☐	Hypothyroidism	☐	Transplantation of Bone Marrow
☐	COPD	☐	History of Hypertension	☐	Immunosuppression	☐	Hepatitis B
☐	Coronary Artery Disease	☐	Hepatitis C	☐	Leukemia	☐	Other:
☐	Other:						

Past Surgical History (please check all past procedures or surgeries) ☐ No past procedures or surgeries

☐	Coronary Artery Disease	☐	History of Appendectomy	☐	Thyroidectomy
☐	Excision of Basal Cell Carcinoma	☐	History of Cholecystectomy (Gallbladder removed)	☐	Transplant of Kidney
☐	Excision of Melanoma	☐	History of Colectomy	☐	Transplantation of Heart
☐	Excision of Squamous Cell Carcinoma	☐	Hysterectomy	☐	Transplantation of Liver
☐	History of Artificial Joint	☐	Mechanical Heart Valve Replacement	☐	Other:
☐	Other:				

Skin Conditions and Skin Disease History (please check all that apply) ☐ None

☐	Acne	☐	Dysplastic Nevus Moles	☐	Psoriasis
☐	Actinic Keratosis	☐	Eczema	☐	Rosacea
☐	Basal Cell Skin Cancer	☐	History of Hay Fever / Allergies	☐	Squamous Cell Skin Cancer
☐	Contact Dermatitis	☐	Melanoma	☐	Sunburn of Second Degree
☐	Other:				

Do you wear Sunscreen? ☐ Yes ☐ No If yes, what SPF? _____	Do you or have you tanned in a tanning bed? ☐ Yes ☐ No

Do you have a family history of Melanoma? ☐ Yes ☐ No
If yes, which relative(s)? _____

Current Medications (include non-prescription products and supplements) ☐ None

Medication	**Strength** (dosage)	**Frequency**	**Route** (oral, topical, etc.)	**Diagnosis** Why do you take this medication?

Today's Date: _____

Patient Name	**Date of Birth**

Allergies (include medication, food, latex, and environmental allergies) ☐ No known allergies	
Allergy	**Type of Reaction** (Check all that apply)
	☐ Itching ☐Swelling ☐Hives ☐Rash ☐Difficulty Breathing ☐Anaphylaxis ☐Other: _____
	☐ Itching ☐Swelling ☐Hives ☐Rash ☐Difficulty Breathing ☐Anaphylaxis ☐Other: _____
	☐ Itching ☐Swelling ☐Hives ☐Rash ☐Difficulty Breathing ☐Anaphylaxis ☐Other: _____
	☐ Itching ☐Swelling ☐Hives ☐Rash ☐Difficulty Breathing ☐Anaphylaxis ☐Other: _____

Are you a tobacco smoker?	Alcohol Intake
☐ Current Smoker ☐ Former Smoker ☐ Never	☐ None ☐ 1 or Less Per Day ☐ 1-2 Per Day ☐ 3 or More Per Day

Patients 65 Years and Older – Advanced Care Plan (if you are 65 years or older, please answer the following questions)

Do you have a health care proxy in the event you are unable to make your own medical decisions? ☐ Yes ☐ No
Designee Name _____ Designee Phone Number _____
Do you have a living will? ☐ Yes ☐ No
Have you had a Pneumonia Vaccine? ☐ Yes ☐ No

Patients Turning 13 Years Old This Year – Immunizations for Adolescents (if the patient is turning 13 years old this year, please answer the following questions)

Has the patient had a meningococcal vaccine on or between the patient's 11th and 13th birthdays? ☐ Yes ☐ No
Has the patient had a tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) on or between the patient's 10th and 13th birthdays? ☐ Yes ☐ No
Has the patient completed the HPV vaccine series on or between the patient's 9th and 13th birthdays? ☐ Yes ☐ No
If **no** was answered to any of the above, did the patient have an anaphylaxis reaction due to one of the above vaccines any time on or before the patient's 13th birthday? ☐ Yes ☐ No

Review of Systems (please check all that apply) ☐ None					
☐	Problems with Bleeding/Bruising	☐	Unintentional Weight Loss	☐	Bloody Urine
☐	Problems with Scarring	☐	Fever or Chills	☐	Joint Aches
☐	Skin Rashes	☐	Night Sweats	☐	Muscle Weakness
☐	Headaches	☐	Abdominal Pain		
☐	Seasonal Allergies	☐	Bloody Stool		

Alerts (please check all that apply) ☐ None					
☐	Allergy to Adhesive/Tape	☐	Artificial Joints (within past two years)	☐	HIV
☐	Allergy to Latex	☐	Blood Thinners	☐	MRSA
☐	Allergy to Lidocaine	☐	Currently Breastfeeding	☐	Premedication Prior to Procedures
☐	Allergy to Topical Antibiotic Ointment	☐	Defibrillator/Pacemaker	☐	Pregnancy or Planning a Pregnancy
☐	Artificial Heart Valve	☐	Hepatitis B or C	☐	Rapid Heartbeat with Epinephrine