CYPRESS DERMATOLOGY

27700 Northwest Freeway Suite 490
Cypress, Texas 77433
281.895.3376 / Fax: 832-708-3049
cypressderm@gmail.com
www.cypressdermatology.com

Intake and History Form

Name: _____ Date: _____

Street Address: _____ City / State: _____

Zip Code: _____ Date of Birth: _____ Gender: _____

Phone Number (day): _____ Phone Number (Night): _____

Email Address: _____

Emergency Contact: _____ Relationship :_____

Phone: _____

Preferred Language: _____ Race: _____ Ethnic Group: _____

Referring Physician: _____ Phone: _____

Primary Care Physician: _____Phone: _____

Address: _____City or Zip Code: _____

Primary Insurance Holder Name: _____ DOB: _____

Address: _____

Insurance Name: _____ Member ID:_____ Group #:_____

Insurance Phone Number: _____

Relation to Patient: _____

Secondary or Supplemental Insurance: _____

Insurance Name: _____ Member ID:_____ Group #:_____

Insurance Phone Number: _____

CYPRESS DERMATOLOGY

Pharmacy Name: _____**Address:** _____

Phone Number: _____

**** "Failure to provide pharmacy information may result in a delay of prescriptions"**

Past Medical History

Select any of the following medical conditions you currently have:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ **NONE**
- ☐ Other

_____

_____

_____

Past Surgical History

Have you had any surgeries on the following organs?

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast: Breast Biopsy
- ☐ Breast: Lumpectomy (Right, Left, Bilateral)
- ☐ Breast: Mastectomy (Right, Left, Bilateral)
- ☐ Joint Replacement: Knee (Right, Left, Bilateral)
- ☐ Colon (Colectomy): Colon Cancer Resection
- ☐ Colon (Colectomy): Diverticulitis
- ☐ Colon (Colectomy): Inflammatory Bowel Disease
- ☐ Colon: Colostomy
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Joint Replacement: Hip (Right, Left, Bilateral
- ☐ Joint Replacement: Knee (Right, Left, Bilateral)

- [ ] Kidney: Kidney Biopsy
- [ ] Kidney: Kidney Stone Removal
- [ ] Kidney: Kidney Transplant
- [ ] Kidney: Nephrectomy
- [ ] Liver: Hepatectomy
- [ ] Liver: Liver Transplant
- [ ] Live: Shunt
- [ ] Ovaries (oophorectomy): Endometriosis
- [ ] Ovaries (Oophorectomy): Ovarian Cancer
- [ ] Ovaries (Oophorectomy): Ovarian Cyst
- [ ] Ovaries: Tubal Ligation
- [ ] Pancreas: Pancreatectomy
- [ ] Prostate (Prostatectomy): Prostate Biops
- [ ] Prostate (Prostatectomy:
- [ ] Prostate Cancer Prostate (Prostatectomy): TUR Rectum: APR
- [ ] Rectum: Low Anterior Resection
- [ ] Skin: Basal Cell Carcinoma
- [ ] Skin: Melanoma
- [ ] Skin: Skin Biopsy
- [ ] Skin: Squamous Cell Carcinoma
- [ ] Spleen (Splenectomy)
- [ ] Testicles (Orchiectomy)
- [ ] Uterus (Hysterectomy): Fibroids
- [ ] Uterus (Hysterectomy): Uterine Cancer
- [ ] Uterus (Hysterectomy): Cervical Cancer
- [ ] NONE
- [ ] Other

_____
_____

Skin Disease History

Have you had any of the following?

- [ ] Acne
- [ ] Actinic Keratoses
- [ ] Asthma
- [ ] Basal Cell Skin Cancer
- [ ] Blistering Sunburns
- [ ] Dry Skin
- [ ] Eczema
- [ ] Flaking or Itchy Scalp
- [ ] Hay Fever / Allergies
- [ ] Melanoma
- [ ] Poison Ivy
- [ ] Precancerous Moles
- [ ] Psoriasis
- [ ] Rosacea
- [ ] Squamous Cell Skin Cancer
- [ ] NONE
- [ ] Other

Do you wear Sunscreen?

◯ Yes ◯ No
If yes, what SPF? _____

Do you tan in a tanning salon?

◯ Yes ◯ N

Do you have a family history of *Melanoma*?

◯ Yes ◯ No

If yes, which relative?

- ☐ Mother
- ☐ Father
- ☐ Sister
- ☐ Brother
- ☐ Daughter
- ☐ Son
- ☐ Uncle
- ☐ Aunt
- ☐ Nephew
- ☐ Niece
- ☐ Grandmother
- ☐ Grandfather
- ☐ Grandson
- ☐ Granddaughter
- ☐ Other

Medications

List all current medications:

_____

_____

Allergies to Medications:

_____

List all allergies and reactions if known:

Smoking Status (please choose one):

- ☐ Current every day smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Unknown if ever smoked

Start Smoking:

- mm/dd/yyyy _____

Quit Smoking:

- mm/dd/yyyy _____

Number of Packs Per Day: _____

Total Years Smoking: _____

Alcohol Intake (please choose one):

- ☐ None
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day
- ☐ Other

How often do you exercise?

- ☐ Once a day
- ☐ Several times a day
- ☐ A few times a week
- ☐ A few times a month
- ☐ A few times a week
- ☐ A few times a month

What is your caffeine use?

- ☐ Unspecified
- ☐ Several times a day
- ☐ Once a day
- ☐ A few times a week
- ☐ A few times a month
- ☐ Other _____
- ☐ Never