Toledo Clinic Dermatologic Surgery INTAKE

My primary care doctor is: _____
The doctor who referred me is: _____

Date:_____ age:_____
Name:_____
MR#:_____
Ins:_____

Indicate any of the following medical conditions you have had or currently have:

- ☐ Thyroid disorder
- ☐ Cataracts or Glaucoma ?
- ☐ Heart Problems_____
- ☐ Rheumatoid Arthritis
- ☐ Artificial Joints
- ☐ Arthritis
- ☐ Eczema
- ☐ Diabetes
- ☐ Kidney Problems
- ☐ Intestinal disorder
- ☐ Rheumatic Fever
- ☐ Hepatitis
- ☐ Internal Cancer
- ☐ Radiation Therapy
- ☐ HIV/AIDS
- ☐ Artificial Heart Valve
- ☐ High Blood Pressure
- ☐ Pacemaker/defibrillator
- ☐ Tuberculosis
- ☐ Skin Cancer
- ☐ Keloids

Previous SURGERIES_____

Are you *currently* experiencing any of the following?

- ☐ Fevers
- ☐ Shaking chills
- ☐ Night sweats
- ☐ Unexplained weight loss
- ☐ Bleeding problems
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Excess thirst
- ☐ insomnia
- ☐ Skin itching
- ☐ Sunburns
- ☐ Joint pain
- ☐ Chest pain
- ☐ Short of breath
- ☐ Palpitations
- ☐ Ankle swelling
- ☐ Depression
- ☐ Anxiety
- ☐ Headaches
- ☐ Numbness
- ☐ seizures
- ☐ Hearing problem
- ☐ Urinary Problems
- ☐ Irregular menses

Are you pregnant or breastfeeding?_____

What medications do you take? Please list dosage and how often you take._____

_____ _____ _____

_____ _____ _____

Height_____ Weight_____

Do you take antibiotics before dental visits? ☐ No ☐ Yes, why?_____

Do you take Aspirin? ☐ No ☐ Yes, why?_Do you take blood thinners?_____

Allergies/reactions *to medications*?

_____

_____

Allergy to Latex?_____

Tobacco Use? Former __ Current __ Never __

Do you drink alcohol?_____

Marital Status?_____

Occupation?_____Hobbies?_____

Do you have an Advance Directive? Yes No_____

Have any of your blood relatives had skin cancer? _____

If yes, whom and what type of cancer?_____

Any comments or other important information the Doctor should know? _____

_____