Precision Skin Care, LLC
1402 S. Main Street
Ottawa, KS 66067
Phone: (785) 749-3600
Fax: (785) 749-3621

Medical History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety	Coronary Artery Disease	Thyroid Problems
Arthritis	Depression	Leukemia
Asthma	End Stage Renal Disease	Lung Cancer
Atrial Fibrillation	GERD	Prostate Cancer
Bone Marrow	Hearing Loss	Radiation Treatment
Transplantation	Hepatitis	Seizures
Breast Cancer	High Blood Pressure	Stroke
Colon Cancer	HIV/AIDS	
COPD	High Cholesterol	NONE

Other_____

_____

Past Surgical History: (please circle all that apply)

Appendix Removed	Joint Replacement within last 2 years
Bladder Removed	Kidney Biopsy (Nephrectomy)
Mastectomy (Right, Left, Bilateral)	Kidney Removed (Right, Left)
Lumpectomy (Right, Left, Bilateral)	Kidney Stone Removal
Breast Biopsy (Right, Left, Bilateral)	Kidney Transplant
Breast Reduction	Ovaries Removed: Endometriosis
Breast Implants	Ovaries Removed: Cyst
Colectomy: Colon Cancer Resection	Ovaries Removed: Ovarian Cancer
Colectomy: Diverticulitis	Prostate Removed: Prostate Cancer
Colectomy: IBD	Prostate Biopsy
Gallbladder Removed	TURP (Prostate Removal)
Coronary Artery Bypass	Spleen Removed
Mechanical Valve Replacement	Testicles Removed (Right, Left, Bilateral)
Biological Valve Replacement	Hysterectomy: Fibroids
Heart Transplant	Hysterectomy: Uterine Cancer
Joint Replacement, Knee (Right, Left, Bilateral)	NONE
Joint Replacement, Hip (Right, Left, Bilateral)	

Other_____

_____

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Skin Disease History: (please circle all that apply)

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

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)

Allergies: (Please enter all allergies)

Social History: (Please circle all that apply)

Cigarette Smoking:

Currently Smokes
Has smoked in the past
Never Smoked
Former Smoker

Alcohol Use:

EtOH – None
EtOH – Less than 1 drink per day
EtOH – 1-2 drinks per day
EtOH – 3 or more drinks per day

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Family History (Only first degree relatives)

_____

_____

_____

_____

_____

Preferred Language: _____

Race: _____ **Ethnic Group:** _____

Preferred Pharmacy Name: _____

Pharmacy Phone #: _____

Pharmacy's City or Zip Code: _____

ALERTS: (please circle all that apply)

- ☐ Allergy to Adhesive
- ☐ Allergy to Lidocaine
- ☐ Allergy to Topical Antibiotics
- ☐ Artificial Heart Valve
- ☐ Artificial Joint Replacement Blood Thinners
- ☐ Defibrillator
- ☐ MRSA
- ☐ Pacemaker
- ☐ Require antibiotics prior to a surgical procedure
- ☐ Rapid heartbeat with epinephrine
- ☐ Are you pregnant or currently trying to get pregnant?