SHAH DERMATOLOGY, LLC

Arpana A. Shah, MD Colleen Clarke, CRNP Angela Callander, CRNP Chris Wood, CRNP

NAME: _____ DOB: _____ DATE:_____

HISTORY AND INTAKE FORM

PAST MEDICAL HISTORY: (PLEASE CIRCLE ALL THAT APPLY)		
Anxiety	Depression	Hypercholesterolemia
Arthritis	Diabetes	Hyperthyroidism/Hypothyroidism
Asthma	End Stage Renal Disease	Leukemia
Atrial fibrillation	Hepatitis	Lung Cancer
Bone Marrow Transplant	Hypertension	Lymphoma
Breast Cancer	HIV/AIDS	Prostate Cancer
Colon Cancer		Radiation Treatment
COPD (Emphysema)		Seizures
Coronary Artery Disease		Stroke
Other:		
NONE		

PAST SURGICAL HISTORY: (PLEASE CIRCLE ALL THAT APPLY)		
Appendix Removed	Heart Transplant	Tubal Ligation
Breast Biopsy	Coronary Artery Bypass	Basal Cell Cancer Surgery
Mastectomy (Both sides, Right, Left)	Mechanical Valve	Melanoma Surgery
Colectomy: Colon Cancer Resection	Replacement	Squamous Cell Carcinoma Surgery
Gallbladder Removed	Kidney Transplant	Hysterectomy: Uterine Cancer
	Liver Transplant	Hysterectomy: Cervical Cancer
Other:		
NONE		

SKIN DISEASE HISTORY: (PLEASE CIRCLE ALL THAT APPLY)		
Acne	Blistering Sunburns	Melanoma
Actinic Keratosis	Dry Skin	Poison Ivy Precancerous Moles
Asthma	Eczema Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Squamous Cell Skin Cancer
Other:		
NONE		

FAMILY HISTORY OF MELANOMA?			YES			NO
Mother Father	Sister Brother	Daughter Son	Uncle Aunt	Nephew Niece	Grandmother Grandfather	Grandson Granddaughter

DO YOU WEAR SUNSCREEN?			YES			NO		
SPF	4	15	30	40	50	70	100	Other:
DO YOU TAN IN TANNING SALONS?			YES			NO		

WHO IS YOUR PRIMARY DOCTOR?		
WERE YOU REFERRED HERE BY A HEALTH CARE PROVIDER? PLEASE PROVIDE THEIR NAME.		
WOULD YOU LIKE US TO SEND YOUR REFERRING DOCTOR A REPORT OF TODAY'S VISIT?	YES	NO

PLEASE TURN OVER PAGE TO FILL OUT BOTH SIDES

SHAH DERMATOLOGY, LLC

Arpana A. Shah, MD Colleen Clarke, CRNP Angela Callander, CRNP Chris Wood, CRNP

CURRENT MEDICATIONS: Please List All Names And Dosages If Known			
NAME OF MEDICATION	DOSAGE	NAME OF MEDICAITON	DOSAGE
NONE			
PLEASE CIRCLE HERE IF YOU HAVE AN ATTACHED LIST.			

ALLERGIES Please List All Medication allergies and reactions if known			
NAME OF MEDICATION	REACTION	NAME OF MEDICATION	REACTION
NONE			
SEE ATTATCHED LIST			

SMOKING STATUS	**ALCOHOL USE**	**OCCUPATION**
Current Daily smoker	None	
Current Some Smoker	Less than 1 drink per day	
Former Smoker	1-2 drinks per day	
Never Smoker	More than 3 drinks per day	

FAMILY HISTORY	
CONDITION	RELATIVE

REVIEW OF SYSTEMS: DO YOU CURRENTLY HAVE THE FOLLOWING?					
NAME	YES	NO	NAME	YES	NO
Fevers Chills			Chest Pain		
Immunosuppression			Cough		
Hay Fever			Shortness of Breath		
Blurry Vision			**Thyroid Problems**		
Sore Throat			Abdominal Pain		
Problems with bleeding			**Depression**		
Problems with healing			**Anxiety**		
Scarring/Keloids			**Joint Aches/Pains**		
Rash			Headache		
Hair Loss			Seizures		

ALERTS?					
NAME	YES	NO	NAME	YES	NO
Pregnant/Planning Pregnancy			Artificial Joints in last 2 years		
Allergy to Adhesive/BandAid			Blood Thinners		
Allergy to Lidocaine			Defibrillator/Pacemaker		
Allergy to NEOSPORIN			Rapid Heartbeat with Epinephrine		
Artificial Heart Valve			Premedication prior to procedures		

Thank you for filling out your paperwork. We appreciate you entrusting us with your healthcare and strive to make your visit a pleasant and informative experience.

–The Dermatology Team at Shah Dermatology, LLC