Kira Minkis, MD, PhD

Director of MOHS and Dermatologic Surgery



PATIENT INTAKE FORM

Name: Age: foday's Date:
Occupation
Name of Referring Physician:
Name of Primary Care Provider (PCP):
Reason for your visit:
How long have you had the problem?
Prior treatments:
Other symptoms: Bleeding Itching Pain Infection
Personal history of skin conditions:
Do you have a family history of skin cancer?
Do you have any of the following conditions?
List any other medical problems:
List past surgeries:
Do you smoke?
Do you drink alcohol?
Do you need antibiotics before routine dental cleaning? 🔲 No 🔲 Yes, reason:
Do you take any of the following medications? Aggrenox Plavix (clopidogrel) Aspirin Pradaxa (dabigatran) Coumadin (warfarin) Vitamin E, Gingko, St John's Wort, Ginseng Pain Medications (List):
Please list all other current medications (including pain medications, vitamins, non-prescription medication):
Diamental Company of the Company of
Pharmacy Information: Name: Telephone Number:
Address/Zip Code
What medication allergies do you have? NONE
Signature of patient: Date:

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REVIEW OF SYSTEMS

Patient Name:					
Constitutional Systems	_		Respiratory		
Fever	☐ No	Yes	Cough	☐ No	Yes Yes
Weight loss or gain	☐ No	Yes	Shortness of breath	☐ No	Yes Yes
Fatigue	☐ No	Yes	Wheezing	☐ No	Yes
Additional information:			Additional information:		
Skin			Gastrointestinal		
Rashes	☐ No	Yes	Swallowing difficulty	☐ No	Yes Yes
Itching or dryness	∐ No	Yes	Vomiting or heartburn	■ No	
New growths	No	Yes	Additional information:		
Changing moles	No	Yes			
Hair or nail changes	No	Yes			
Additional information:			Margarlaghalatal		
			Musculoskeletal	Пио	□ Voc
			Joint pain, swelling, redness Muscle pain or cramps	∐ No □ No	Yes Yes
Eyes					☐ 1es
Loss of vision	□ No	Yes	Additional information:		
Fluctuating vision	□ No	Yes			
Eye pain or soreness	□ No	Yes			
•			Nouvological		
Additional information:			Neurological Headaches	□ No	☐ Yes
			Numbness or tingling	□ No	Yes
			Weakness or paralysis	□ No	Yes
Ears, Nose, Mouth, Throat					1es
Ringing or dizziness	☐ No	Yes	Additional information:		
Sinus congestion	□ No	Yes			
Nosebleeds	☐ No	Yes			
Dryness or hoarseness	□ No	Yes	Davahiatria		
-		163	Psychiatric	Пмо	□ Voc
Additional information:			Anxiety	∐ No	☐ Yes
			Depression	∐ No	☐ Yes
			Additional information:		
Cardiovascular					
Chest pain or palpitations	∐ No	∐ Yes		_	
Swollen ankles	∐ No	∐ Yes	Hematology/ Lymphatics/	_	
Valve disorder	☐ No		Easy bruising or bleeding	☐ No	Yes
Additional information:			Blood transfusions	∐ No	∐ Yes
		<u>.</u>	Lumps on glands	☐ No	☐ Yes
			Additional information:		