Melissa Watcher, M.D., Susan W. Cox, M.D., Hui-Kyung Tina Kim, M.D.
Premier Dermatology Associates of Orange County
20162 SW Birch Street, Suite 250 • Newport Beach, CA 92660
Office 949-251-0427 • Fax 949-251-0480

HISTORY AND INTAKE FORM

Name: ______________________________ Date of Birth: ___________ Date: _____________

Past medical history: (Please circle all that apply)

Anxiety	COPD (Emphysema)	Hypertension	Pacemaker
Arthritis	Depression	HIV / AIDS	Thyroid Disease
Atrial fibrillation	Diabetes	GERD (Acid Reflex)	Stroke
Asthma	Heart Disease	Organ Transplant	Seizures
BPH	Hepatitis	Kidney Disease / Dialysis	

Cancer: ____

None Other: ____

Past Surgical History: (Please circle all that apply)

Heart Surgery	Joint Replacement(s): ______________________	
Organ Transplant	Prostate Removed	
Ovaries Removed	Skin Cancer Surgery	
Spleen Removed	Hysterectomy	None

Other: ____

Skin Disease History: (Please circle all that apply)

Acne	Dry, Itchy Skin or Scalp	Melanoma
Actinic Keratoses	Eczema	Psoriasis
Basal Cell Skin Cancer	Hay Fever / Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Precancerous Moles	None

Other: ____

Do you wear Sunscreen? Yes No

Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No

If yes, which relative(s)? ____

Is there any other family history? ____

PLEASE FILL OUT FRONT AND BACK

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Medications (Please list all current medications):

____

____

Allergies (Please list all allergies):

____

____

Social History

Smoking Status:

Never Smoker□ Former Smoker□ Cigar Smoker□ Current Every day Smoker□

Start Date: ________ Quit Date: ________ Number of packs per day: ___________ Total years Smoking: ____

Do you drink alcohol?

Yes No If yes, ________ drinks/day

How many times in the past year have you had the following:

5+ drinks in a day for men **OR** 4+ drinks in a day for women **OR** any drinks for adults 65+? ____ # days

Are you pregnant? Yes No If yes, how many weeks? ________________

Recreational drugs? Yes No If yes, what drugs? ___________________________

Immunization:

Have you had your Influenza Vaccine this or prior year? Yes□ No□ Declined□ If yes, when? ___________

Have you had your Pneumonia Vaccine within the past 5 years? Yes□ No□ Declined□ If yes, when? __________

Have you had your Zoster (Shingles) Vaccine? Yes□ No□ No□ Declined□ If yes, when? __________

Have you had your Tetanus Vaccine? Yes□ No□ Declined□ If yes, when? __________

Have you had your COVID Vaccine? Yes□ No□ Declined□ If yes, when? __________

What is your occupation? ____

***May we leave a detailed message on your phone? Yes No Phone: ____________________**

Pharmacy Information

Name: ____ Phone: _________________________

Address if known: ____ City: ___________________________

Pediatric History (only for minors)

Gestational age at birth: _________weeks Birth Weight: _____ lbs _______ oz

Maternal illness during pregnancy: ____

Immunization: Meningococcal vaccine: Yes□ No□ Tdap vaccine: Yes□ No□ HPV vaccine: Yes□ No□

Completed by: ____ Date: __________________

Signed by patient or responsible party

PLEASE FILL OUT FRONT AND BACK