Kira Minkis, MD, PhD
Director of MOHS and Dermatologic Surgery

Weill Cornell Medical College

PATIENT INTAKE FORM

Name: _____ Age: _____ Today'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: ☐ **NONE**

☐ Abnormal moles ☐ Thick scars / Keloids ☐ Radiation treatment for acne
☐ Melanoma ☐ Skin Cancer ☐ Other: _____

Do you have a **family history** of skin cancer? ☐ No ☐ Yes, type: _____

Do you have any of the following conditions? ☐ **NONE**

☐ Artificial joint ☐ High blood pressure ☐ Asthma / COPD
☐ Artificial heart valve ☐ Bleeding problems ☐ AIDS / HIV infection
☐ Implanted deep brain stimulator ☐ Blood clots ☐ Organ transplant
☐ Pacemaker / defibrillator ☐ Other cancer ☐ Diabetes
☐ Stroke / heart attack ☐ Hepatitis

List any other medical problems: _____

_____

_____

_____

List past surgeries: _____

_____

Do you smoke? ☐ Yes ☐ No If yes, how much daily? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how much per week? _____

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):

_____

_____

_____

_____

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

Fever	☐ No	☐ Yes
Weight loss or gain	☐ No	☐ Yes
Fatigue	☐ No	☐ Yes

Additional information:

_____
_____

Skin

Rashes	☐ No	☐ Yes
Itching or dryness	☐ No	☐ Yes
New growths	☐ No	☐ Yes
Changing moles	☐ No	☐ Yes
Hair or nail changes	☐ No	☐ Yes

Additional information:

_____
_____

Eyes

Loss of vision	☐ No	☐ Yes
Fluctuating vision	☐ No	☐ Yes
Eye pain or soreness	☐ No	☐ Yes

Additional information:

_____
_____

Ears, Nose, Mouth, Throat

Ringing or dizziness	☐ No	☐ Yes
Sinus congestion	☐ No	☐ Yes
Nosebleeds	☐ No	☐ Yes
Dryness or hoarseness	☐ No	☐ Yes

Additional information:

_____
_____

Cardiovascular

Chest pain or palpitations	☐ No	☐ Yes
Swollen ankles	☐ No	☐ Yes
Valve disorder	☐ No	☐ Yes

Additional information:

_____
_____

Respiratory

Cough	☐ No	☐ Yes
Shortness of breath	☐ No	☐ Yes
Wheezing	☐ No	☐ Yes

Additional information:

_____
_____

Gastrointestinal

Swallowing difficulty	☐ No	☐ Yes
Vomiting or heartburn	☐ No	☐ Yes

Additional information:

_____
_____

Musculoskeletal

Joint pain, swelling, redness	☐ No	☐ Yes
Muscle pain or cramps	☐ No	☐ Yes

Additional information:

_____
_____

Neurological

Headaches	☐ No	☐ Yes
Numbness or tingling	☐ No	☐ Yes
Weakness or paralysis	☐ No	☐ Yes

Additional information:

_____
_____

Psychiatric

Anxiety	☐ No	☐ Yes
Depression	☐ No	☐ Yes

Additional information:

_____
_____

Hematology/ Lymphatics/ Immunology

Easy bruising or bleeding	☐ No	☐ Yes
Blood transfusions	☐ No	☐ Yes
Lumps on glands	☐ No	☐ Yes

Additional information:

_____
_____

Other symptoms not listed above: _____