Sonterra Dermatology PLLC
Annabelle L. García, M.D.

History and Intake Form

NAME:_____ **DATE OF BIRTH:**_____

Reason for your visits: _____
_____
How long have you had this problem: _____
Symptoms (How does it bother you): _____
Treatments you have tried: _____

Referred by:

Dr. (Name) _____ Family Member (Name) _____
Friend (Name) _____ Google (X) ____ Yelp (X) _____
Print Ad _____ Website (X) _____ Other_____

Past Medical History: (please circle all that apply)

Anxiety	Colon Cancer	Hearing Loss	Leukemia
Arthritis	COPD-Emphysema	Hepatitis	Lung Cancer
Asthma	Coronary Artery Disease	Hypertension	Lymphoma
Atrial fibrillation	Depression	HIV/AIDS	Prostate Cancer
Bone Marrow Transplantation	Diabetes	Hypercholesterolemia	Radiation Treatment
BPH (Benign Prostatic Hyperplasia)	End Stage Renal Disease	Hyperthyroidism	Seizures
Breast Cancer	GERD (Acid reflux)	Hypothyroidism	Stroke
		Hyperhidrosis or Excessive Sweating	None

Other _____

Past Surgical History: (please circle all that apply)

Appendix: Removed	Heart:	Liver:	Skin:
Bladder: Removed	-Coronary Artery Bypass	-Hepatectomy	-Basal Cell Carcinoma
Breast: Mastectomy (Right, Left, Both)	-Mechanical Valve Replacement	-Transplant	-Squamous Cell Carcinoma
Breast: Lumpectomy (Right, Left, Both)	-Transplant	-Shunt	-Melanoma
Breast: Biopsy	-PTCA	Ovaries Removed:	Skin: Biopsy
Colon: Removed	Joint Replacement:	-Endometriosis	Spleen: Removed
-Colon Cancer Resection	-Hip (Right, Left, Both)	-Cyst	Testicles: Removed (Right, Left, Both)
-Diverticulitis	-Knee (Right, Left, Both)	-Ovarian Cancer	Uterus
-Inflammatory Bowel Disease	Kidney:	Ovaries:	Hysterectomy:
Gallbladder:	-Biopsy	-Tubal Ligation	-Fibroids
-Removed	-Removed (Right, Left)	Pancreas: Removed	-Uterine Cancer
Heart:	-Stone Removal	Prostate Removed:	-Cervical Cancer
-Biological Valve Replacement	-Transplant	-Prostate Cancer	None
		-Biopsy	
		-TURP	
		Rectum: APR	
		Rectum: Low Anterior Resection	

Other _____

Skin Disease History: (please circle all that apply)

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

Other _____

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Are you pregnant? Yes No

Do you wear Sunscreen? Yes No If yes, what SPF? _____

Do you tan in a tanning salon? Yes No

When you are exposed to sunlight do you: (Check most applicable)
___ Always burn ____Sometimes burn, tan well
___Usually burn, rarely tan ____Rarely burn, always tan
___Often burn, tan slowly ____Never burn, deeply tan

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____
Any other family history: _____

Medications: (Please enter all current medications)
_____
_____

Allergies: (Please enter all allergies)
_____
_____

Pharmacy: Name:_____
Street:_____ City: _____ State: _____ Zip Code:_____
Telephone #:_____

Social History: (Please circle one)

Cigarette Smoking:
Never smoked
Quit: former smoker
Smoker: Less than daily
Smoker: Daily

Alcohol Use:
YES
NO

Language:
English
Spanish
Other: _____

How often do you exercise?
Once a day
A few times a week
A few times a month
Never

What is your caffeine use?
Once a day
A few times a week
A few times a month
Never

History of?
Drug Use
IV Drug Use
Blood transfusions
Unprotected intercourse
Intercourse multiple partners
Same Sex Partner

Animals in home? _____ Hobbies: _____

Are you interested in discussing any cosmetic treatments during your visit? (Please circle all that apply)

Wrinkles (Botox)	Fine Lines (Fillers)	Skin Care Advice	Facial / Body Hair Reduction
Body Contouring	Laser Resurfacing	Underarm Sweating	Neck Fullness (Double chin)
Chemical Peels	Facial / Leg Veins	Blotchy Skin	Non-invasive Facial Lift
Facial Redness	Drooping Eyelids	CoolSculpting	Brown / Age Spots or Freckles
Brow lift	Under Eye Bags	Thinning Lips	Facial / Body Skin Tightening