Patient Name: _____ DOB: _____

History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
High Blood pressure
HIV/AIDS
High Cholesterol
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke

NONE

Other _____

Medications: (Please enter all current medications)

_____
_____
_____

Allergies: (Please enter all allergies)

_____
_____
_____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)

Past Surgical History Continued:

Colectomy: Diverticulitis
Joint Replacement, Hip (Right, Left, Bilateral)
Other Joint Replacement - last 2 yrs
Kidney Biopsy (Nephrectomy)
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP (Prostate Removal)
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer

NONE

Other _____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer

NONE

Other _____

Do you wear Sunscreen? Yes No
If yes, what SPF? _____
Do you tan in a tanning salon? Yes No

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

Social History: (Please circle all that apply)

Cigarette Smoking:

Currently Smokes
Never smoked
Former Smoker

Alcohol Use:

None
Less than 1 drink per day
1-2 drinks per day
3 or more drinks per day

Preferred Language: _____

Race:_____ Ethnic Group:_____

Preferred pharmacy Name: _____

Pharmacy Phone#: _____

Pharmacy City, Zip code and/or Crossroads/Location:_____

Primary Care Physician Name: _____

City: _____

Review of Systems: Are you currently experiencing any of the following?
(Please check yes or no for the following)

Symptom	Yes	No
Problems with healing		
Problems with bleeding		
Problems with scarring		
Enlarged lymph nodes other than illness		
Immunosuppression		

Other Symptoms: _____

ALERTS: (please circle all that apply)

Allergy to Adhesive
Allergy to topical antibiotic ointments
Allergy to systemic antibiotics
Allergy to carbocaine
Problems with numbing agents
Artificial heart valve
Defibrillator
Pacemaker
Artificial joint replacement within the past 2 years
Blood thinners
Are you pregnant or currently trying to get pregnant?
HIV positive