History and Intake Form

Today's Date: __________

Patient's Name: Last_________________________, First _____________________ Middle _________________

Past Medical History: (please circle all that apply) **NONE**

Anxiety	Arthritis	Asthma
Irregular heart Beat (atrial Fibrillation)	Bone marrow transplant	Breast cancer
Benign prostatic hyperplasia	Colon Cancer	COPD
Coronary artery disease	Depression	Diabetes
End stage renal disease	GERD	Hearing loss
Hepatitis	Hypertension	HIV/AIDS
High Cholesterol	Hyperthyroidism	Hypothyroidism
Leukemia	Lung cancer	Lymphoma
Prostate cancer	Radiation therapy	Seizures
Stroke		

Other: ____

Past Surgical History: (please circle all that apply) **NONE**

Appendix removal	Joint replacement within the last 2 years
Bladder removal	Kidney Biopsy (Nephrectomy)
Mastectomy (Right, Left, Bilateral)	Kidney removed (Right, Left)
Lumpectomy (Right, Left, Bilateral)	Kidney stone removal
Breast reduction	Ovaries removed: Endometriosis
Breast implants	Ovaries removed: Ovarian cyst
Colectomy: Colon cancer resection	Ovaries removed: Ovarian cancer
Colectomy: Diverticulitis	Prostate removal: Prostate cancer
Colectomy: IBD	Prostate biopsy
Gallbladder removal	TURP (Prostate removal)
Coronary artery bypass	Spleen removal
Mechanical valve replacement	Testicle removed (right, Left, Bilateral)
Biologic valve replacement	Hysterectomy: Fibroids
Heart transplant	Hysterectomy: Uterine cancer
Joint replacement, Knee (right, left, Bilateral)	Joint replacement, Hip (right, Left, Bilateral)

Other: ____

Skin Disease History: (please circle all that apply) **NONE**

Acne	Basal Cell skin cancer	Eczema	Actinic Keratosis
Blistering sunburns	Flaking or itchy scalp	Asthma	Dry skin
Hay fever/Allergies	Poison Ivy	Psoriasis	Squamous Cell skin Cancer
Precancerous moles	Melanoma		

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)?

____

Medications: (Please enter all current prescription and over-the-counter medications including supplements)

Medication Allergies: (please enter all allergies)

Medication:	Reaction:
Medication:	Reaction:
Medication:	Reaction:
Medication:	Reaction:
Medication:	Reaction:
Medication:	Reaction:
Medication:	Reaction:
Medication:	Reaction:
Medication:	Reaction:
Medication:	Reaction:

Other allergies (including environmental allergies):

____

____

Social History: Please circle all that apply)

Cigarette Smoking:
Currently smokes
Has smoked in the past
Never smoked
Former smoker – Quit _____months/years ago

Alcohol Use:
Alcohol – None
Alcohol – less than 1 drink per day
Alcohol – 1-2 drinks per day

Preferred Language: ____________________________

Race: _______________________ **Ethnic Group:** ____________________

Preferred pharmacy Name: ________________________________ Phone Number: ___________________________

Address: ____ **City/zip code:** ___________________________________

May we leave a detailed message on your primary phone voice mail: Yes No
May we discuss your condition with your spouse? Yes No Other named person: __________________________

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

Symptom	Yes	No
Problems with bleeding		
Problems with healing		
Problems with scarring		
Rash		
Immunosuppression		
Hay fever		
Chest Pain		
Fever or chills		
Night sweats		
Unintentional weight loss		
Thyroid problems		
Sore throat		
Blurry vision		
Abdominal pains		
Bloody stool		
Bloody urine		
Joint aches		
Muscle weakness		
Neck Stiffness		
Headaches		
Seizures		
Cough		
Shortness of breath		
Wheezing		
Anxiety		
Depression		
Irregular menses (female)		
Hearing loss/Deafness		

Other symptoms: ____

ALERTS: (please circle all that apply)

Personal history of melanoma
Family history of melanoma
Anaphylaxis
Allergy to Lidocaine
Allergy to topical antibiotics
Allergy to oral antibiotics
Blood thinners
Latex allergy
Artificial joints within the past two years
Artificial Heart Valve
Pacemaker Ebola Risk:

Rapid heartbeat with epinepherine
Pregnancy or planning pregnancy
Nursing
Asthma
Dementia
MRSA
West Africa: Travel or Contact
Ebola Risk: Fever > 100.4 degrees (F)/38.0 degrees (C)
Ebola Risk: Resided or Travel to in last 21 days
Ebola Risk: Contact with Ebola patient in last 21 days
headache, weakness, muscle pain, vomiting,
diarrhea, abdominal pain, and/or hemorrhage

Name of referring physician: ____

Name of primary care physician (if different from above): ________________________________

Patient's or responsible party's Signature: ______________________________________