History and Intake Form

Name: _____ **DOB:** _____ **Date:** _____

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone Marrow Transplantation
BPH
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: _____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Breast Biopsy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Mastectomy (Right, Left, Bilateral)
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Colostomy
Gallbladder Removed
Biological Valve Replacement
Coronary Artery Bypass Surgery
Heart Transplant
Mechanical Valve Replacement
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement, Knee (Right, Left, Bilateral)
Kidney Biopsy
Kidney Stone Removal
Kidney Transplant
Kidney Removed (Right, Left)
Liver Transplant
Liver Shunt
Ovaries Removed: Endometriosis
Ovaries Removed: Ovarian Cancer
Ovaries Removed: Cyst
Tubal Ligation
Pancreas Removed
Prostate Biopsy
Prostate Removed: Prostate Cancer
TURP (Prostate Removal)
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
Hysterectomy: Cervical Cancer

NONE
Other: _____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
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)? _____

Current Medications:

Medication	Strength	Dose	Form (i.e. tablet)	Frequency	Indication

Allergies: (Please list all allergies)

_____

_____

_____

Social History: (Please circle all that apply)

Cigarette Smoking:

Currently Smokes
Has smoked in the past
Never smoked
Former Smoker

Alcohol Use:

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

Other: _____

Family History: (Only first degree relatives: i.e. skin cancer, skin problems, diseases, disorders, etc.)

_____

_____

****PHARMACY INFO****

Preferred Pharmacy Name: _____

Pharmacy Location: _____

Primary Care Physician: _____

Referring Physician (if applicable): _____

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

Symptom	YES	NO	Symptom	YES	NO
Problems with bleeding			Headaches		
Problems with healing			Seizures		
Problems with scarring (hypertrophic or keloid)			Cough		
Rash			Shortness of breath		
Immunosuppression			Wheezing		
Hay fever			Anxiety		
Chest pain			Depression		
Fevers or chills			History of cold sores		
Night sweats			Photosensitivity		
Unintentional weight loss			Swollen lymph nodes		
Thyroid problems			Lumps, bumps and growths		
Sore throat			Nausea and vomiting		
Vision changes			Bone pain		
Abdominal pain			Skin dryness		
Bloody stool			Numbness/tingling		
Bloody urine			Leg swelling		
Joint aches			Eye discomfort		
Muscle weakness			Trouble swallowing		
Neck stiffness					

Other Symptoms: _____

ALERTS: (please circle all that apply)

Personal history of melanoma
Hearing impaired
HIV
Hepatitis
History of transplant
Vasovagal
Allergy to latex
Allergy to adhesive
Allergy to lidocaine
Allergy/rapid heart rate with Epinephrine
Allergy to topical antibiotic
NONE

Artificial heart valve
Blood thinners
Premedication prior to procedures
Defibrillator
Pacemaker
Cochlear implant
Deep brain stimulator
Artificial joint replacement within past two years
Are you pregnant or currently trying to get pregnant?

Other Symptoms: _____

Email address: _____