

History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety	Coronary Artery Disease	Thyroid Problems
Arthritis	Depression	Leukemia
Asthma	Diabetes	Lung Cancer
Atrial fibrillation	End Stage Renal Disease	Lymphoma
Bone Marrow Transplantation	GERD	Prostate Cancer
Breast Cancer	Hearing Loss	Radiation Treatment
Colon Cancer	Hepatitis	Seizures
COPD	High Blood pressure	Stroke
	HIV/AIDS	NONE
	High Cholesterol	

Other _____

Past Surgical History: (please circle all that apply)

Appendix Removed	Joint Replacement within last 2 years
Bladder Removed	Kidney Biopsy (Nephrectomy)
Mastectomy (Right, Left, Bilateral)	Kidney Removed (Right, Left)
Lumpectomy (Right, Left, Bilateral)	Kidney Stone Removal
Breast Biopsy (Right, Left, Bilateral)	Kidney Transplant
Breast Reduction	Ovaries Removed: Endometriosis
Breast Implants	Ovaries Removed: Cyst
Colectomy: Colon Cancer Resection	Ovaries Removed: Ovarian Cancer
Colectomy: Diverticulitis	Prostate Removed: Prostate Cancer
Colectomy: IBD	Prostate Biopsy
Gallbladder Removed	TURP (Prostate Removal)
Coronary Artery Bypass	Spleen Removed
Mechanical Valve Replacement	Testicles Removed (Right, Left, Bilateral)
Biological Valve Replacement	Hysterectomy: Fibroids
Heart Transplant	Hysterectomy: Uterine Cancer
Joint Replacement, Knee (Right, Left, Bilateral)	NONE
Joint Replacement, Hip (Right, Left, Bilateral)	
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 _____

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 medications)

Allergies: (Please enter all allergies)

Social History: (Please circle all that apply)

Cigarette Smoking:

- Currently Smokes
- Has smoked in the past
- Never smoked
- Former Smoker

Alcohol Use:

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

Other _____

Family History (Only first degree relatives)

Preferred Language: _____

Race: _____ Ethnic Group: _____

Preferred pharmacy Name: _____

Phone#: _____

City or Zip code: _____

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

Symptom	Yes	No
changing mole		
Problems with bleeding		
Problems with healing		
Problems with scarring (hypertrophic or keloid)		
immunosuppression		
rash		
Abdominal pain		
anxiety		
Bloody stool		
Bloody urine		
Blurry vision		
Chest pain		
cough		
depression		
Fever or chills		
headaches		
Hay fever		
Joint aches		
Muscle weakness		
Neck stiffness		
Night sweats		
seizures		
Shortness of breath		
Sore throat		
Thyroid problems		
Unintentional weight loss		
wheezing		

Other Symptoms: _____

ALERTS: (please circle all that apply)

- Allergy to Adhesive
- Allergy to lidocaine
- Allergy to topical antibiotics
- Artificial heart valve
- Artificial joint replacement
- Blood thinners
- Defibrillator
- MRSA
- Pacemaker
- Require antibiotics prior to a surgical procedure
- Rapid heart beat with epinephrine
- Are you pregnant or currently trying to get pregnant?