

Name: _____ Date: _____

Preferred language: _____

Race: _____ Ethnic Group: _____

Primary Provider Name: _____

Preferred Pharmacy: _____ # _____

History and Intake Form

Past Medical History: (please check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> Lung Cancer |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> GERD | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> Bone Marrow Transplantation | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> BPH | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Hypercholesterolemia | |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> None |
| <input type="checkbox"/> Other | | |
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Past Surgical History: (please check all that apply)

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|---|--|
| <input type="checkbox"/> Appendix Removed | <input type="checkbox"/> Kidney Biopsy |
| <input type="checkbox"/> Bladder Removed | <input type="checkbox"/> Kidney Removed (Right, Left) |
| <input type="checkbox"/> Mastectomy (Right, Left, Bilateral) | <input type="checkbox"/> Kidney Stone Removal |
| <input type="checkbox"/> Lumpectomy (Right, Left, Bilateral) | <input type="checkbox"/> Kidney Transplant |
| <input type="checkbox"/> Breast Biopsy (Right, Left, Bilateral) | <input type="checkbox"/> Ovaries Removed: Endometriosis |
| <input type="checkbox"/> Breast Reduction | <input type="checkbox"/> Ovaries Removed: Cyst |
| <input type="checkbox"/> Breast Implants | <input type="checkbox"/> Ovaries Removed: Ovarian Cancer |
| <input type="checkbox"/> Colectomy: Colon Cancer Resection | <input type="checkbox"/> Prostate Removed: Prostate Cancer |
| <input type="checkbox"/> Colectomy: Diverticulitis | <input type="checkbox"/> Prostate Biopsy |
| <input type="checkbox"/> Colectomy: IBD | <input type="checkbox"/> TURP - Prostatectomy |
| <input type="checkbox"/> Gallbladder Removed | <input type="checkbox"/> Skin Biopsy |
| <input type="checkbox"/> Coronary Artery Bypass | <input type="checkbox"/> Basal Cell Cancer Surgery |
| <input type="checkbox"/> PTCA | <input type="checkbox"/> Squamous Cell Carcinoma Surgery |

- | | |
|---|---|
| <input type="checkbox"/> Mechanical Valve Replacement | <input type="checkbox"/> Melanoma Surgery |
| <input type="checkbox"/> Biological Valve Replacement | <input type="checkbox"/> Spleen Removed |
| <input type="checkbox"/> Heart Transplant | <input type="checkbox"/> Testicles Removed (Right, Left, Bilateral) |
| <input type="checkbox"/> Joint Replacement, Knee (Right, Left, Bilateral) | <input type="checkbox"/> Hysterectomy: Fibroids |
| <input type="checkbox"/> Joint Replacement, Hip (Right, Left, Bilateral) | <input type="checkbox"/> Hysterectomy: Uterine Cancer |
| <input type="checkbox"/> Joint Replacement within last 2 years | <input type="checkbox"/> None |
| <input type="checkbox"/> Other _____ | |
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Skin Disease History: (please check all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Eczema | <input type="checkbox"/> Precancerous Moles |
| <input type="checkbox"/> Actinic Keratoses | <input type="checkbox"/> Flaking or Itchy Scalp | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Basal Cell Skin Cancer | <input type="checkbox"/> Hay Fever/Allergies | <input type="checkbox"/> Squamous Cell Skin Cancer |
| <input type="checkbox"/> Blistering Sunburns | <input type="checkbox"/> Melanoma | <input type="checkbox"/> None |
| <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Poison Ivy | |
| <input type="checkbox"/> Other _____ | | |
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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 check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Not sexually active | <input type="checkbox"/> Alcohol consumption: None |
| <input type="checkbox"/> Sexually active with one partner | <input type="checkbox"/> Alcohol consumption: Less than 1 drink per day |
| <input type="checkbox"/> Sexually active with more than one partner | <input type="checkbox"/> Alcohol consumption: 1-2 drinks per day |
| <input type="checkbox"/> Same sex partner | <input type="checkbox"/> Alcohol consumption: 3 or more drinks per day |
| <input type="checkbox"/> Drug use | <input type="checkbox"/> None |
| <input type="checkbox"/> IV Drug use | |
| <input type="checkbox"/> Other | |
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Smoking Status: (Please check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Current every day smoker | <input type="checkbox"/> Never smoked |
| <input type="checkbox"/> Current some day smoker | <input type="checkbox"/> Smoker current status unknown |
| <input type="checkbox"/> Former smoker | <input type="checkbox"/> Unknown if ever smoked |

Cautions / Alerts: (Please check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Allergy to adhesive: rash | <input type="checkbox"/> Defibrillator |
| <input type="checkbox"/> Allergy to Lidocaine: itching | <input type="checkbox"/> MRSA |
| <input type="checkbox"/> Allergy to Lidocaine: palpitations | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Allergy to Lidocaine: sweating | <input type="checkbox"/> Patient vasovagal |
| <input type="checkbox"/> Allergy to topical antibiotic ointments | <input type="checkbox"/> Personal history of malignant melanoma |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Premedication prior to procedures |
| <input type="checkbox"/> Artificial joints within past two years | <input type="checkbox"/> Rapid heartbeat with epinephrine |
| <input type="checkbox"/> Blood thinners | <input type="checkbox"/> Pregnancy or planning a pregnancy |

Review of Systems: Are you currently experiencing any of the following?
(Please check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> New hair growth on face, chest or abdomen | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> New Moles | <input type="checkbox"/> Unintentional weight loss |
| <input type="checkbox"/> Problems with bleeding/easy bruising | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Problems with healing | <input type="checkbox"/> Blurry vision |
| <input type="checkbox"/> Problems with scarring (hypertrophic or keloid) | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Rash | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Sensitivity to sunlight | <input type="checkbox"/> Bloody stool |
| <input type="checkbox"/> Significant change in existing moles | <input type="checkbox"/> Bloody urine |
| <input type="checkbox"/> Significant hair loss | <input type="checkbox"/> Joint aches |

- | | |
|---|--|
| <input type="checkbox"/> Significant persistent or intermittent burning of the skin | <input type="checkbox"/> Muscle weakness |
| <input type="checkbox"/> Significant persistent or intermittent itching of the skin | <input type="checkbox"/> Neck stiffness |
| <input type="checkbox"/> Currently having menstrual periods | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Irregular menstrual cycle | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Hay fever | <input type="checkbox"/> Cough |
| <input type="checkbox"/> Immunosuppression | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Palpitations, irregular heart beat | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Fever or chills | <input type="checkbox"/> Depression |