Patient Name: _____ **DOB:** _____

History and Intake Form

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

Acute hepatitis	Diabetes mellitis	Malignant:
Anxiety disorder	Disease caused by Covid 19	☐ Lymphoma
Arthritis	Elevated blood pressure	☐ Tumor of lung
Asthma	End stage kidney disease	☐ Tumor of breast
Benign prostatic hyperplasia	Hearing loss	☐ Tumor of colon
Cancer; Type: _____	HIV infection	☐ Tumor of prostate
Chronic obstructive lung disease	High cholesterol	Radiation therapy
Coronary heart disease	History of thyroid disorder	Stroke
Depressive disorder	Leukemia	Other:_____
		_____

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

Excision of basal cell carcinoma
Excision of melanoma
Excision of squamous cell carcinoma
Heart: Valve replacement
Hysterectomy
Surgical biopsy of skin
Transplant; ☐ Bone marrow ☐ Heart ☐Liver
Joint replacement; ☐Hip R/L Both ☐Knee R/L Both
Vasectomy
Other:_____

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

Acne	Contact derm due to poison ivy	Malignant melanoma
Actinic keratosis	Eczema	Psoriasis
Asthma	History of hay fever	Squamous cell cancer
Basal cell skin cancer	History of atypical nevus	Sunburn (2nd degree)
Complaining of dry skin	Itchy scalp	

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: ☐ **NONE**
(Please enter all current medications-include dosages and supplement names)

_____
_____
_____
_____

Please see next page --->

Drug Allergies: *(Please enter all allergies and **reactions**)* ☐ **NONE**

_____

_____

What is your smoking status: ☐ Unknown ☐ Never smoker ☐ Current everyday smoker
☐ Current some day smoker (cigar) ☐ Current some day smoker (cigarette)
☐ Former smoker ☐ Cigar smoker ☐ Heavy tobacco smoker ☐ Light tobacco smoker

How many times in the past year have you had 5 or more drinks in a day for men,
or 4 or more drinks in a day for women or any adult older than 65?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9

Do you consume alcohol?
☐ None ☐Less than 1 drink per day ☐ 1-2 drinks per day ☐ 3 or more drinks per day

ALERTS: *(Please circle all that apply)*

☐ **NONE**

Are you pregnant or currently trying to get pregnant?

Allergy to Adhesive

Allergy to Lidocaine

Allergy to topical Antibiotics

Allergy to Latex

Artificial Heart Valve

Artificial Joint within the past 2 years

Blood Thinners

Defibrillator

MRSA

Pacemaker

Require Antibiotics prior to a surgical procedure.

Rapid heartbeat with Epinephrine

HIV/ Hepatitis B or C

Personal History of Melanoma