History and Intake Form

Name: _____

Past Medical History: Please circle all that apply

Anxiety
Arthritis
Asthma
Atrial Fibrillation
Bone Marrow/
Stem Cell Transplant
Organ Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Kidney Disease
GERD
Hearing Loss
Hepatitis
High Blood Pressure
HIV/AIDS
High Cholesterol
Thyroid Problems:
Hypothyroidism
Hyperthyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Seizures
Stroke
None

Other _____

Past Surgical History: Please circle all that apply

Appendix removed
Bladder removed
Mastectomy (Right/Left/Bilateral)
Lumpectomy (Right/Left/Bilateral)
Breast Biopsy (Right/Left/Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
Mechanical Valve Replacement
Biological Valve Replacement
Joint Replacement: Knee
(Right/Left/Bilateral)
Joint Replacement: Hip
(Right/Left/Bilateral)
Hernia Repair
Joint replacement in the last 2 years
Kidney Biopsy
Kidney Removed (Right/Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cysts
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
Transurethral Resection of the Prostate
Spleen Removed
Testicles Removed (Right/Left/Center)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
Tonsillectomy
None

Other _____

Skin Disease History: Please circle all that apply

Acne	Dry Skin	Poison Ivy
Actinic Keratoses	Eczema	Abnormal 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 use a tanning bed? YES NO

Do you have a family history of melanoma? YES NO If yes, what relative? _____

Medications and Dosages:

Medication Allergies and Reaction:

Social History: Please circle all that apply

Cigarette Smoking:

Currently Smoke
Never Smoked
Former Smoker

Alcohol Use:

None
Less than 1 drink per day
1-2 drinks per day
3 -5 drinks per day
Woah baby!

Preferred Pharmacy Name: _____

Phone #: _____

City or Zip Code: _____

Preferred Language: _____

Family History
(only first degree relatives)

	YES	NO	Afflicted Family Member and Diagnosis
Acne			
Autoimmune Disorder – What diagnosis if yes?			
Cancer – What kind?			
Diabetes			
Endocrine Disease – What diagnosis if yes?			
Hemophilia			
Skin Cancer – What kind?			
Skin Disease			
Other			

Alerts: Please circle all that apply

Allergy to adhesive

Allergy to lidocaine

Allergy to topical antibiotics

Artificial heart valve

Artificial joint replacement in the past 2 years

Blood thinners

Defibrillator

MRSA

Pacemaker

Require antibiotics prior to surgical procedure

Rapid heartbeat with epinephrine

Are you pregnant or currently trying to get pregnant? YES NO N/A