Patient Intake Form

Name: _____ Date of Birth _____ Date: _____

Preferred Pharmacy

Name: _____Phone: _____ City _____

Past Medical History

Select any of the following medical conditions you currently have:

- Anxiety
- Arthritis
- Asthma
- Atrial Fibrillation
- Bone Marrow Transplant
- Enlargement of prostate
- 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

Have you had any surgeries on the following organs?

- Heart: Pacemaker
- Heart: Mechanical Valve Replacement
- Breast: Lumpectomy (Right | Left | Bilateral)
- Breast: Mastectomy (Right | Left | Bilateral)
- Gallbladder: _____
- Joint Replacement: Knee (Right | Left | Bilateral)
- Joint Replacement: Hip (Right | Left | Bilateral)
- Other:_____
- Colon: _____
- Liver: _____
- Kidney: _____
- Ovaries: _____
- Prostate: _____
- Uterus: _____

Please turn page over

Skin Disease History

Have you had any of the following?

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Asthma
- ☐ 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?

- ☐ Mother
- ☐ Father
- ☐ Sister
- ☐ Brother
- ☐ Daughter
- ☐ Son
- ☐ Other:

_____
_____

Medications

List all current medications; Please include strength, unit, route, dose, form, and frequency: Can we import medications from your pharmacy? **Yes** **No**

_____
_____
_____
_____
_____

Any Known Drug Allergies

List all drug allergies if known:

_____
_____
_____
_____

Social History

Smoking Status (please choose one):

- ☐ Current everyday smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Unknown if ever smoked

Number of days in the past year you had Alcohol (please choose):

- ☐ None
- ☐ 1-3 per day, on _____ occasions in a year
- ☐ 4+ per day, on _____ occasions in a year
- ☐ 5+ per day, on _____ occasions in a year

Family History of Skin Cancer

Please include only first-degree relatives:

_____
_____
_____

Other Medical

Have you had the Pneumonia vaccine?

☐ Yes ☐ No

Do you have advanced care planning in place?

☐ Yes ☐ No

Do you have a healthcare surrogate?

☐ Yes ☐ No

If yes, Provide the name of your surrogate.

_____

Have you had the Influenza vaccine?

☐ Yes ☐ No

If no, please explain: Allergy or Other_____