HISTORY AND INTAKE FORM

Patient Name: _____ Patient DOB: _____

Today's Date: _____

Reason for Today's Visit: _____

Past Medical History: (Please circle all that apply)

Anxiety	Depression	High Blood Pressure	Lymphoma
Arthritis/Osteoarthritis	Diabetes	HIV/AIDS	Multiple Sclerosis
Asthma	End Stage Renal Disease	High Cholesterol	Rheumatoid Arthritis
Atrial Fibrillation	Fibromyalgia	Hyperthyroid	Seizures
Bone Marrow Transplant	GERD	Hypothyroid	Stroke
COPD	Hearing Loss	Leukemia	**NONE**
Coronary Artery Disease	Hepatitis	Lupus	

Cancer: _____

Other: _____

Past Surgical History: (Please circle all that apply)

Appendix Removed	Coronary Artery Bypass	Ovaries Removed
Bladder Removed	Mechanical Valve Replacement	Prostate Removed
Breast Biopsy (Right/Left)	Biological Valve Replacement	Spleen Removed
Lumpectomy (Right/Left)	Hip Replacement (Right/Left)	Testicles Removed
Mastectomy (Right/Left)	Knee Replacement (Right/Left)	Thyroid Removed
Breast Implants	Kidney Biopsy	Partial Hysterectomy
Colectomy	Kidney Stone Removal	Full Hysterectomy
Gallbladder Removed	Kidney Removed (Right/Left)	**NONE**

Organ Transplant: _____

Other: _____

Skin Disease History: (Please circle all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratosis	Eczema	Psoriasis
Asthma	Flaking or Itchy Scalp	Rosacea
Atypical Moles	Hay Fever	Shingles
Basal Cell Skin Cancer	Seasonal Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	**NONE**

Other: _____

Do you wear sunscreen? **YES** **NO** If yes, what SPF? _____

Do you or have you ever tanned in a tanning salon? **YES** **NO** When? _____

Do you have family history of Melanoma? **YES** **NO**

If yes, which relative(s)? _____

Do you have family history of Non-Melanoma Skin Cancer? **YES** **NO**

If yes, which 1st degree relative(s)? _____

(PLEASE COMPLETE BACKSIDE)

Medications & Dosages: (Please list all current medications and dosages)

_____

_____

_____

Drug Allergies: (Please list all medication allergies)

_____

_____

_____

Alerts: (Please circle all that apply)

Allergy to Adhesive	Artificial Heart Value	Pacemaker
Allergy to Lidocaine	Blood Thinners	Defibrillator
Allergy to Topical Antibiotics	MRSA	Other Electronic Implanted Device

Have you had a joint replacement within last 2 years? **YES** **NO**
Does epinephrine give you rapid heartbeat? **YES** **NO**
Do you require antibiotics prior to a surgical procedure? **YES** **NO**
Do you have a history of fainting? **YES** **NO**
Are you pregnant or currently trying to get pregnant? **YES** **NO**

Vaccine History: (Please circle all that apply)
Have you had the flu vaccine? **YES** **NO** When? _____
Have you had the pneumonia vaccine? (65 or older) **YES** **NO**

Preferred Pharmacy Name: _____

Pharmacy Phone #: _____ City or Zip Code: _____

Social History: (Please circle all that apply)

Cigarette Smoking:	**Alcohol Use:**
Currently Smoke Cigarettes	3 or more drinks per day
Smoke Electronic Cigarettes	1-2 drinks per day
Have Smoked in the past	Less than 1 drink per day
Never Smoked	**NONE**

Occupation: _____ Hobbies: _____

Preferred Language: _____ Race: _____

Ethnic Group: _____

Details/Comments: _____

_____

_____