History and Intake Form

****PLEASE DO NOT LEAVE ANYTHING BLANK****

Name:_____

D.O.B_____

Past Medical History: (Please circle all that apply)

Anxiety	Bone Marrow Transplant	End Stage Renal Disease	Leukemia
Arthritis	Breast Cancer	GERD	Lung Cancer
Asthma	Colon Cancer	Hearing Loss	Lymphoma
Atrial Fibrillation	COPD	HIV/AIDS	Prostate Cancer
Blood Clots	Coronary Artery Disease	High Cholesterol	Seizures
Blood Diseases	Depression	Hypothyroid	Stroke
Anemia	Diabetes	Hyperthyroid	Radiation
BPH	Hypertension	Psychological Problems	Psychiatric Problems

NONE Other:_____

Past Surgical History: (Please circle all that apply)

Appendix Removed	Coronary Artery Bypass	Kidney Stone Removal
Bladder Removed	Mechanical Valve Replacement	Kidney Transplant
Mastectomy(Right, Left, Both)	Biological Valve Replacement	Ovaries Removed: Cyst
Lumpectomy(Right, Left, Both)	Heart Transplant	Ovaries Removed:Ovarian Cancer
Breast Biopsy(Right, Left, Both)	Joint Replacement:Hip (Right, Left)	Ovaries Removed: Endometriosis
Breast Reduction	Joint Replacement:Hip (Both)	Prostate Removed:Prostate Cancer
Breast Implants	Joint Replacement:Knee (Right, Left)	Prostate Biopsy
Colectomy-Colon Cancer Resection	Joint Replacement:Knee (Both)	TURP: Prostate Removal
Colectomy-Diverticulitis	Kidney Biopsy	Spleen Removed
Colectomy-IBD	Kidney Removed (Right, Left)	Testicles Removed(Right, Left)
Hysterectomy: Uterine Cancer	Hysterectomy: Fibroids	Testicles Removed (Both)
		Gallbladder Removed

NONE Other:_____

Skin Disease History: (Please circle all that apply)

Acne	Flaking or Itchy Scalp	Poison Ivy
Actinic Keratoses	Hay Fever or Allergies	Precancerous Moles
Asthma	Impetigo	Psoriasis
Basal Cell Skin Cancer	Melanoma	Squamous Cell Skin Cancer
Blistering Sunburns	Melasma (pregnancy mask)	Eczema

NONE Other:_____

Do you wear sun screen? 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**?_____

Medications: (Please list all current medications)

_____

_____

_____**NONE**

Medication Allergies (Please list all allergies)

_____

_____

_____**NONE**

****PLEASE TURN OVER AND COMPLETE BACK SIDE****

Social History: (Please circle all that apply)

Cigarette/Tobacco	**Alcohol Use:**
Current Everyday Smoker	EtOH- Less than 1 drink per day
Current Some day Smoker	EtOH- 1 to 2 drinks per day
Former Smoker	EtOH- 3 or more drinks per day
Heavy Tobacco Smoker	EtOH- **NONE**
Light Tobacco Smoker	
NEVER Smoker	Other:_____

Please list any family history of skin cancer or any other pertinent disease/cancer:(first degree relatives only)_____

_____

What skin problems are you experiencing?_____
When did it start?_____
What have you treated it with?_____
Which problem concerns you most?_____

Place of Birth:_____ **Ethnic Group**: Hispanic/Latino
CITY STATE COUNTRY Non-Hispanic/Latino
Preferred Language:_____ Decline to specify
Race:_____
Preferred Pharmacy:_____
Pharmacy Phone #:_____
Pharmacy City or Zip Code:_____
Preferred Contact Phone #:_____
Email Address:_____
Employer/Occupation:_____
Emergency Contact: Name:_____ **Phone #**_____
Spouse: Name:_____ **Phone#**_____

ALERTS: (please circle all that apply)

Allergy To Adhesive	Defibrillator	Trying To Become Pregnant
Allergy To Lidocaine	MRSA	Require Antibiotics Prior To Procedures
Artificial Heart Valve	Pace Maker	Traveled Or Had Contact With West Africa
Blood Thinners	Pregnant	HIV
Hepatis C		
NONE		

Review Of Systems: Are you currently experiencing any of the following? (Please circle yes or no)

Problems with bleeding	Yes	No	Joint aches	Yes	No	Unintentional weight loss	Yes	No
Problems with healing	Yes	No	Muscle weakness	Yes	No	Thyroid problems	Yes	No
Problems with scarring	Yes	No	Neck stiffness	Yes	No	Sore throat	Yes	No
Rash	Yes	No	Headaches	Yes	No	Blurry Vision	Yes	No
Immunosuppression	Yes	No	Seizure	Yes	No	Abdominal pain	Yes	No
Hay fever	Yes	No	Cough	Yes	No	Bloody stool	Yes	No
Chest pain	Yes	No	Shortness of breath	Yes	No	Bloody urine	Yes	No
Fever or chills	Yes	No	Wheezing	Yes	No	Depression	Yes	No
Night sweats	Yes	No	Anxiety	Yes	No			

Other:_____