Name: _____Date:_____

Preferred language: _____

Race: _____Ethnic Group: _____

Preferred Pharmacy: _____ # _____

History and Intake Form

Past Medical History: (please check all that apply)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Bone Marrow Transplantation
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ None
- ☐ Other _____

Past Surgical History: (please check 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 Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Gallbladder Removed
- ☐ Coronary Artery Bypass
- ☐ PTCA
- ☐ Kidney Biopsy
- ☐ Kidney Removed (Right, Left)
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Ovaries Removed: Endometriosis
- ☐ Ovaries Removed: Cyst
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Prostate Removed: Prostate Cancer
- ☐ Prostate Biopsy
- ☐ TURP - Prostatectomy
- ☐ Skin Biopsy
- ☐ Basal Cell Cancer Surgery
- ☐ Squamous Cell Carcinoma Surgery

- [ ] Mechanical Valve Replacement
- [ ] Biological Valve Replacement
- [ ] Heart Transplant
- [ ] Joint Replacement, Knee (Right, Left, Bilateral)
- [ ] Joint Replacement, Hip (Right, Left, Bilateral)
- [ ] Joint Replacement within last 2 years
- [ ] Other _____
- [ ] Melanoma Surgery
- [ ] Spleen Removed
- [ ] Testicles Removed (Right, Left, Bilateral)
- [ ] Hysterectomy: Fibroids
- [ ] Hysterectomy: Uterine Cancer
- [ ] None

Skin Disease History: (please check all that apply)

- [ ] Acne
- [ ] Actinic Keratoses
- [ ] Basal Cell Skin Cancer
- [ ] Blistering Sunburns
- [ ] Dry Skin
- [ ] Other _____
- [ ] Eczema
- [ ] Flaking or Itchy Scalp
- [ ] Hay Fever/Allergies
- [ ] Melanoma
- [ ] Poison Ivy
- [ ] Precancerous Moles
- [ ] Psoriasis
- [ ] Squamous Cell Skin Cancer
- [ ] None

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)? _____

Medications: (Please enter all current medications)

_____

_____

_____

_____

_____

_____

Allergies: (Please enter all allergies)

_____

_____

_____

_____

_____

_____

Social History: (Please check all that apply)

- ☐ Not sexually active
- ☐ Sexually active with one partner
- ☐ Sexually active with more than one partner
- ☐ Same sex partner
- ☐ Drug use
- ☐ IV Drug use
- ☐ Other _____

- ☐ Alcohol consumption: None
- ☐ Alcohol consumption: Less than 1 drink per day
- ☐ Alcohol consumption: 1-2 drinks per day
- ☐ Alcohol consumption: 3 or more drinks per day
- ☐ None

Smoking Status: (Please check all that apply)

- ☐ **Current every day smoker**
- ☐ **Current some day smoker**
- ☐ **Former smoker**
- ☐ **Never smoked**
- ☐ **Smoker current status unknown**
- ☐ **Unknown if ever smoked**

Cautions / Alerts: (Please check all that apply)

- ☐ Allergy to adhesive: rash
- ☐ Allergy to Lidocaine: itching
- ☐ Allergy to Lidocaine: palpitations
- ☐ Allergy to Lidocaine: sweating
- ☐ Allergy to topical antibiotic ointments
- ☐ Artificial heart valve
- ☐ Artificial joints within past two years
- ☐ Blood thinners
- ☐ Defibrillator
- ☐ MRSA
- ☐ Pacemaker
- ☐ Patient vasovagal
- ☐ Personal history of malignant melanoma
- ☐ Premedication prior to procedures
- ☐ Rapid heart beat with epinephrine
- ☐ Pregnancy or planning a pregnancy

Review of Systems: Are you currently experiencing any of the following? (Please check all that apply)

- ☐ New hair growth on face, chest or abdomen
- ☐ New Moles
- ☐ Problems with bleeding/easy bruising
- ☐ Problems with healing
- ☐ Problems with scarring (hypertrophic or keloid)
- ☐ Rash
- ☐ Sensitivity to sunlight
- ☐ Significant change in existing moles
- ☐ Significant hair loss
- ☐ Night sweats
- ☐ Unintentional weight loss
- ☐ Thyroid problems
- ☐ Blurry vision
- ☐ Sore throat
- ☐ Abdominal pain
- ☐ Bloody stole
- ☐ Bloody urine
- ☐ Joint aches

- [ ] Significant persistent or intermittent burning of the skin
- [ ] Significant persistent or intermittent itching of the skin
- [ ] Currently having menstrual periods
- [ ] Irregular menstrual cycle
- [ ] Hay fever
- [ ] Immunosuppression
- [ ] Chest Pain
- [ ] Palpitations, irregular heart beat
- [ ] Fever or chills
- [ ] Muscle weakness
- [ ] Neck stiffness
- [ ] Headaches
- [ ] Seizures
- [ ] Cough
- [ ] Shortness of breath
- [ ] Wheezing
- [ ] Anxiety
- [ ] Depression