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
- [ ] Other
- [ ] 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

____

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
- [ ] Melanoma Surgery
- [ ] Spleen Removed
- [ ] Testicles Removed (Right, Left, Bilateral)
- [ ] Hysterectomy: Fibroids
- [ ] Hysterectomy: Uterine Cancer
- [ ] None
- [ ] Other ______________________________

Skin Disease History: (please check all that apply)

- [ ] Acne
- [ ] Actinic Keratoses
- [ ] 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(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
- [ ] 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
- [ ] Other ______________________________

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