

Intake and History Form

Name: _____ Date: _____

Street Address: _____ City / State: _____

Zip Code: _____ Date of Birth: _____ Gender: _____

Phone Number (mobile) _____ Phone Number (other) _____

Email Address: _____

Emergency Contact: _____

Preferred Language: _____ Race: _____ Ethnic Group: _____

Preferred Pharmacy

Name: _____

Phone Number: _____

City or Zip Code: _____

Primary Care Physician

Name (First and Last): _____

Phone Number: _____

City or Zip Code: _____

Past Medical History

Select any of the following medical conditions you currently have:

- Anxiety
- Arthritis
- Asthma
- Atrial Fibrillation
- Bone Marrow Transplant
- 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

Pacemaker? Yes / No

Defibrillator? Yes / No

Other implantable device(s)? Yes / No

If yes, what type? _____

Artificial joints (ex. knee replacement)? Yes / No

If yes, what type and when? _____

Other metal implants (ex. screws, plates)?

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Past Surgical History

Have you had any surgeries on the following organs?

- Appendix (Appendectomy)
- Bladder (Cystectomy)
- Breast: Breast Biopsy
- Breast: Lumpectomy (Right, Left, Bilateral)
- Breast: Mastectomy (Right, Left, Bilateral)
- Colon (Colectomy): Colon Cancer Resection
- Colon (Colectomy): Diverticulitis
- Colon (Colectomy): Inflammatory Bowel Disease
- Colon: Colostomy
- Gallbladder (Cholecystectomy)
- Heart: Coronary Artery Bypass Surgery
- Heart: Heart Transplant
- Heart: Mechanical Valve Replacement
- Heart: PTCA
- Joint Replacement: Hip (Right, Left, Bilateral)
- Joint Replacement: Knee (Right, Left, Bilateral)
- Kidney: Kidney Biopsy
- Kidney: Kidney Stone Removal
- Kidney: Kidney Transplant
- Kidney: Nephrectomy
- Liver: Hepatectomy
- Liver: Liver Transplant
- Live: Shunt

- Ovaries (Oophorectomy): Endometriosis
- Ovaries (Oophorectomy): Ovarian Cancer
- Ovaries (Oophorectomy): Ovarian Cyst
- Ovaries: Tubal Ligation
- Pancreas: Pancreatectomy
- Postate (Prostatectomy): Prostate Biopsy
- Prostate (Prostatectomy): Prostate Cancer
- Prostate (Prostatectomy): TURP
- Rectum: APR
- Rectum: Low Anterior Resection
- Skin: Basal Cell Carcinoma
- Skin: Melanoma
- Skin: Skin Biopsy
- Skin: Squamous Cell Carcinoma
- Spleen (Splenectomy)
- Testicles (Orchiectomy)
- Uterus (Hysterectomy): Fibroids
- Uterus (Hysterectomy): Uterine Cancer
- Uterus (Hysterectomy): Cervical Cancer
- NONE
- Other

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Skin Disease History

Have you had any of the following?

- Acne
- Actinic Keratoses
- Asthma
- Basal Cell Skin Cancer
- Blistering Sunburns
- Dry Skin
- Eczema
- Flaking or Itchy Scalp
- Have 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
- Uncle
- Aunt
- Nephew
- Niece
- Grandmother
- Grandfather
- Grandson
- Granddaughter
- Other

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Medications

List all current medications:

Allergies

List all allergies and reactions if known:

Social History

Smoking Status (please choose one):

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

Start Smoking:

- mm/dd/yyyy _____

Quit Smoking:

- mm/dd/yyyy _____

Number of Packs Per Day: _____

Total Years Smoking: _____

Alcohol Intake (please choose one):

- None
- 1 or less per day
- 1-2 per day
- 3 or more per day

Where have you lived? (Currently and in the past)

Hobbies:

Occupation and Workplace

Have you had a flu shot during this flu season? (October through March)

Yes / No

Have you received the pneumococcal (pneumonia) vaccine?

Yes / No

