Patient Intake Form

Name: _____ **Date of Birth:** _____ **Date:** _____

Preferred Pharmacy

Name: _____ **Phone:** _____ **City:** _____

Preferred Laboratory to Send Specimens

Name: _____ Please note: We use **KorPath** for our specimens. Results may take 2-3 weeks to come back. All benign results will be posted to the patient portal. You will be contacted ONLY if you need to schedule treatment

Past Medical History

Select any of the following medical conditions you currently have:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ Enlargement of prostate
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV / AIDS
- ☐ High Cholesterol
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ NONE
- ☐ Other

_____

_____

_____

_____

_____

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Past Surgical History

Have you had any surgeries on the following organs?

- ☐ Heart: Pacemaker
- ☐ Heart: Mechanical Valve Replacement
- ☐ Breast: Lumpectomy (Right I Left I Bilateral)
- ☐ Breast: Mastectomy (Right I Left I Bilateral)
- ☐ Gallbladder: _____
- ☐ Joint Replacement: Knee (Right I Left I Bilateral)
- ☐ Joint Replacement: Hip (Right I Left I Bilateral)
- ☐ Other: _____
- ☐ Colon: _____
- ☐ Liver: _____
- ☐ Kidney: _____
- ☐ Ovaries: _____
- ☐ Prostate: _____
- ☐ Uterus: _____
- ☐ NONE

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
- ☐ Other:

_____

_____

If any skin cancers, please list location and date of skin cancer:

_____

_____

Medications

List all current medications:

	Name of medication	Unit	Route (Oral, Injection, etc)	Dosage	Form (Pill, Cream, etc)	Frequency (How often)
1						
2						
3						
4						
5						
6						

Can we import medications from your pharmacy? ☐ **Yes** ☐ **No**

Any Known Drug 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

Number of days in the past year you had Alcohol (please choose):

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

****Please turn page over****

Family History of Skin Cancer

Please include only first-degree relatives:

_____

_____

_____

Other Medical

Have you had the Pneumonia vaccine?

☐ **Yes** ☐ **No**

Have you had the Influenza vaccine?

☐ **Yes** ☐ **No**

If no, please explain: Allergy or Other: _____

_____

Do you have advanced care planning in place?

☐ **Yes** ☐ **No**

Do you have a health surrogate?

☐ **Yes** ☐ **No**

If yes, provide the name of your surrogate: _____