Patient Intake Form

Name: _____ Date of Birth _____ Date: _____

Preferred Pharmacy

Name: _____ Phone: _____ City _____

Preferred Laboratory to Send Specimens

Name: _____ Please note: We use CarePath 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
- ☐ Enlargement of prostate
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ 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

_____
_____
_____
_____

Please turn page over

Past Surgical History

Have you had any surgeries on the following organs?

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

Skin Disease History

Have you had any of the following?

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Asthma
- ☐ 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

_____

_____

If any skin cancers please list location and date skin cancer._____

_____

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:

_____

_____

Medications

List all current medications within the chart below;

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 drug allergies 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
- ☐ 1-3 per day, on _____ occasions in a year
- ☐ 4+ per day, on _____ occasions in a year
- ☐ 5+ per day, on _____ occasions in a year

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

Do you have advanced care planning in place?

☐ Yes ☐ No

Do you have a healthcare surrogate?

☐ Yes ☐ No

If yes, Provide the name of your surrogate.

_____

Have you had the Influenza vaccine?

☐ Yes ☐ No

If no, please explain: Allergy or Other_____