Intake and History Form

Name: _____

Street Address: _____ City / State: _____

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

Phone Number (day): _____ Phone Number (night): _____

Email Address: _____

Emergency Contact: _____

Preferred Language: _____ Race: _____ Ethnic Group:_____

Primary Care Provider: _____ Referred by: _____

Preferred Pharmacy

Name: _____

Phone Number: _____

City or Zip Code: _____

Past Medical History

Select any of the following medical conditions you currently have:

- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Benign prostatic hyperplasia
- ☐ Cerebrovascular accident
- ☐ Chronic obstructive lung disease
- ☐ Coronary arteriosclerosis
- ☐ Depressive disorder
- ☐ Diabetes mellitus
- ☐ Disease caused by 2019-nCoV
- ☐ Elevated blood pressure
- ☐ End-stage renal disease
- ☐ Epilepsy
- ☐ Gastroesophageal reflux disease
- ☐ Hearing Loss
- ☐ H/O Hypertension
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Inflammatory Disease of Liver
- ☐ Leukemia
- ☐ Malignant Lymphoma
- ☐ Malignant tumor of lung/breast/colon (which one)
- ☐ Malignant tumor of Prostate
- ☐ Radiation Therapy
- ☐ Transplantation of bone marrow
- ☐ NONE
- ☐ Other

_____

_____

_____

Past Surgical History

Have you had any surgeries on the following organs?

- ☐ Abdominoperineal resection (APR)
- ☐ Bilateral replacement of knee joints
- ☐ Biopsy of breast
- ☐ Biopsy of prostate
- ☐ Coronary artery bypass graft
- ☐ Entire transplanted kidney
- ☐ Excision of basal cell carcinoma
- ☐ Excision of melanoma
- ☐ Excision of squamous cell carcinoma
- ☐ H/O: Colostomy
- ☐ H/O: Tubal ligation
- ☐ History of appendectomy
- ☐ History of bilateral mastectomy
- ☐ History of cholecystectomy
- ☐ History of colectomy
- ☐ History of liver excision
- ☐ History of percutaneous transluminal coronary angioplasty
- ☐ History of tissue graft heart valve replacement
- ☐ History of total cystectomy
- ☐ History of transurethral prostatectomy
- ☐ Hysterectomy
- ☐ Kidney biopsy
- ☐ Low anterior resection of rectum
- ☐ Lumpectomy of breast
- ☐ Lumpectomy of left breast
- ☐ Lumpectomy of right breast
- ☐ Mastectomy of left breast
- ☐ Mastectomy of right breast
- ☐ Mechanical heart valve replacement
- ☐ Oophorectomy
- ☐ Pancreatectomy
- ☐ Percutaneous extraction of kidney stone
- ☐ Portosystemic shunt operation
- ☐ Prostatectomy
- ☐ Prosthetic arthroplasty of bilateral hips
- ☐ Splenectomy
- ☐ surgical biopsy of skin
- ☐ Total nephrectomy
- ☐ Total orchidectomy
- ☐ Total replacement of left hip joint
- ☐ Total replacement of right hip joint
- ☐ Total replacement of left knee joint
- ☐ Total replacement of right knee joint
- ☐ Transplantation of heart
- ☐ Transplantation of liver
- ☐ None
- ☐ Other:

_____
_____
_____

Skin Disease History

Have you had any of the following?

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Asteatosis cutis
- ☐ Basal Cell Skin Cancer
- ☐ Contact dermatitis due to poison ivy
- ☐ Dysplastic nevus
- ☐ Eczema
- ☐ History of asthma
- ☐ History of Hay Fever
- ☐ Malignant Melanoma
- ☐ Pruritus of scalp
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ Sunburn of second degree
- ☐ 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 include dosage and frequency:

_____
_____
_____

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

Driving Status:

- ☐ Drives in the Daytime
- ☐ Drives at Night

How often do you exercise?

- ☐ Unspecified
- ☐ Several times a day
- ☐ Once a day
- ☐ A few times a week
- ☐ A few times a month
- ☐ Never
- ☐ Other _____

What is your caffeine use?

- ☐ Unspecified
- ☐ Several times a day
- ☐ Once a day
- ☐ A few times a week
- ☐ A few times a month
- ☐ Never
- ☐ Other _____

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Pneumonia vaccination ☐ **YES** ☐ **NO**

Do you have a health care proxy? ☐ **YES** ☐ **NO**
Designee's name_____ Designee's phone number_____

Do you have a Living will? ☐ **YES** ☐ **NO**

Review of Systems

Please check yes or no for the following:

Symptom	Yes	No
Allergy to adhesive – rash	☐	☐
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	☐	☐
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	☐	☐
Palpitations, irregular heart beat	☐	☐
Unintentional weight loss	☐	☐
Thyroid problems	☐	☐
Joint aches	☐	☐
Anxiety	☐	☐
Depression	☐	☐

Alerts

Please check yes or no for the following:

Symptom	Yes	No
Allergy to lidocaine – itching	☐	☐
Allergy to lidocaine – palpitations	☐	☐
Allergy to lidocaine – sweating	☐	☐
Allergy to topical antibiotic ointments	☐	☐
Allergy to – latex	☐	☐
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 heartbeat with epinephrine	☐	☐
Pregnancy or planning pregnancy	☐	☐