

History and Intake Form

Name _____

Email _____

Please indicate the 2 main problems you want addressed at today's visit.

Problem #1 _____

Problem #2 _____

Past Medical History: *(Please circle all that apply)*

Asthma	Hepatitis	Prostate Cancer
Breast Cancer	High Blood pressure	Radiation treatment
Colon Cancer	HIV/ AIDS	Thyroid Disease (Hypo/Hyper)
Coronary Artery Disease	Leukemia	Strokes
Diabetes	Lung Cancer	NONE

Other _____

Past Surgical History: *(Please circle all that apply)*

Heart Valve Replacement
Joint Replacement within last 2 years / Location _____
Other _____

Skin Disease History: *(Please circle all that apply)*

Actinic Keratosis	Hay Fever/Allergies	Squamous Cell Skin Cancer
Asthma	Melanoma	Seborrhea / Dandruff
Basal Cell Skin Cancer	Precancerous Moles	NONE
Eczema/Dermatitis	Psoriasis	

Other _____

Do you wear Sunscreen? Yes/No

What SPF? _____

Do you tan in a tanning salon? Yes/No

Flu Shot? Yes/No

Pneumonia Shot? Yes/No

Do you have a family history of Melanoma? Yes/No **Which relative(s)?** _____

Medications: (Please list all current medications)

Allergies: (Please list all allergies)

Social History:

Cigarette Smoking *(Please circle)*

Current Smoker

Former Smoker

Never Smoked

Alcohol Consumption Yes/No If yes how many? _____

Family History: *(Only first degree relative)* of Cancer, Hereditary Disease (i.e. Diabetes, Hypertension)

Employer: _____ **Occupation:** _____

Preferred Language: _____

Race: White / Asian / African American / Other

Ethnic Group: Hispanic / Non-Hispanic / Unknown

Preferred Pharmacy: _____ **Phone#** _____ **City or Zip code:** _____

Primary Care Provider: _____ **Phone #** _____

Review of Systems:

Do you have problems with? *(Please circle yes or no)*

Bleeding: Yes / No

Excessive Scarring: Yes / No

Slow Healing: Yes / No

ALERTS: (please circle all that apply)

Allergy to Adhesive

Allergy to lidocaine

Allergy to topical antibiotics

Artificial heart valve

Artificial joint replacement

Blood thinners

Defibrillator

Hearing / Visually Impaired

MRSA history

Pacemaker

Require antibiotics prior to a surgical procedure

Rapid heart beat with epinephrine

Are you pregnant or currently trying to get pregnant