Name: _____ DOB: _____ Date: _____

HISTORY and INTAKE FORM

***Past Medical History*: (please check all that apply)**

- □ Anxiety
- □ Arthritis
- □ Asthma
- □ Atrial fibrillation(irregular heartbeat)
- □ Bone Marrow Transplant
- □ Benign Prostatic Hypertrophy
- □ 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
- □ Thyroid (Hyper or Hypo)
- □ Leukemia
- □ Lung Cancer
- □ Lymphoma
- □ Prostate cancer
- □ Radiation Treatment
- □ Seizures
- □ Stroke
- □ Other_____
- □ **NONE**

***Past Surgical History*: (please check all that apply)**

- □ Appendix Removed
- □ Bladder Removed
- □ Breast Biopsy: (R, L, Bilateral)
- □ Lumpectomy: (R, L, Bilateral)
- □ Mastectomy: (R, L, Bilateral)
- □ Colectomy: Colon cancer resection
- □ Colectomy: Diverticulitis
- □ Colectomy: IBD
- □ Colon: Colostomy
- □ Gallbladder Removed (cholecystectomy)
- □ Biologic Valve Replacement
- □ Coronary Artery Bypass Surgery
- □ Heart Transplant
- □ Mechanical Valve Replacement
- □ Heart: PTCA (angioplasty) or Stents _____
- □ Joint replacement: Hip (R, L, Bilateral)
- □ Joint replacement: Knee (R, L, Bilateral)
- □ Kidney biopsy
- □ Kidney Stone Removal
- □ Kidney Transplant
- □ Kidney Removed (Nephrectomy)
- □ Liver: Hepatectomy
- □ Liver: Transplant
- □ Liver: Shunt
- □ Ovaries Removed: Endometriosis
- □ Ovaries Removed: Ovarian Cancer
- □ Ovaries Removed: Cyst
- □ Ovaries: Tubal Ligation
- □ Pancreas: Pancreatectomy
- □ Prostate (prostatectomy): Biopsy
- □ Prostate (prostatectomy): Cancer
- □ Prostate (prostatectomy): TURP
- □ Rectum: APR (abdominalperineal Resection Surgery)
- □ Rectum: Low Anterior Resection
- □ Skin: Basal Cell Carcinoma
- □ Skin: Melanoma
- □ Skin: Skin Biopsy
- □ Skin: Squamous Cell Carcinoma
- □ Spleen Removed
- □ Testicles Removed: (R, L, Bilateral)
- □ Hysterectomy: Fibroids
- □ Hysterectomy: Uterine Cancer
- □ Hysterectomy: Cervical Cancer
- □ Other _____ _____
- □ **NONE**

***Skin Disease History*: (please check all that apply)**

- □ 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
- □ Other_____
- □ **NONE**

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?	

Family History of Skin Cancer? □ ***No*** □ ***Yes*** *(please describe below)*
Basal Cell or Squamous Cell *Type* _____ *Relative(s)* _____ *Type* _____ *Relative(s)* _____

Medications: (Please enter all current medications, strength, dosage & frequency) □ ***No Current Medications***

Allergies: (Please enter all allergies, describe type of reaction) □ **NKDA'S** *(No Known Drug Allergies)*

_____

_____

_____

Social History: (Please circle all that apply)

Cigarette Smoking:	*Alcohol (EtOH) Use:*
Currently Smokes: Start Date	EtOH- None
Never smoked	EtOH- Less than 1 drink per day
Former Smoker	EtOH- 1-2 drinks per day
Total Years Smoked	EtOH- 3 or more drinks per day

Drug use:

Drug use:	Yes	No
IV Drug Use:	Yes	No
Other:		

Occupation and Workplace

Preferred Pharmacy Name	Phone #	City or Zip Code

<u>Alerts</u> (please check all that apply)

□ Allergy to Latex
□ Allergy to Lidocaine
□ Allergy to Adhesive
□ Allergy to Topical Antibiotic Ointments
□ History of MRSA
□ History of Hepatitis
□ HIV Positive
□ Immunosuppression
□ Blood thinners
□ Problems with Bleeding
□ Problems with Scarring (hypertropic or Keloid)
□ Problems with Healing
□ Anxiety
□ Artificial Heart Valve
□ Defibrillator
□ Pacemaker
□ Artificial Joints within past 2 years
□ Rapid Heart beat with Epinephrine
□ Pregnancy or planning a pregnancy
□ West Africa: Travel or contact
□ Ebola Risk: Fever (> =100.4), any symptoms of Ebola
□ Ebola: contact w/pt w/o proper protective equipment in the last 21 days.
□ History of Inflammatory Bowel Disease
□ Eye Grittiness
□ Menses Irregular
□ Diabetes – type 1 or type 2
□ History PCOS (Poly Cystic Ovarian Syndrome)
□ NONE

Height: _____ Weight: _____ Signature: _____

Name: _____ DOB: _____ Date: _____