Name: _____ **Account #** _____ **Date** _____

HISTORY AND INTAKE FORM

Past Medical History: (please check all that apply)

☐ Anxiety	☐ Breast Cancer	☐ End Stage Renal Disease	☐ High Cholesterol	☐ Radiation Treatment
☐ Arthritis	☐ Colon cancer	☐ GERD	☐ Thyroid Hyper or Hypo	☐ Seizures
☐ Asthma	☐ COPD	☐ Hearing Loss	☐ Leukemia	☐ Stroke
☐ Atrial fibrillation	☐ Coronary Artery Disease	☐ Hepatitis	☐ Lung Cancer	
☐ Bone Marrow Transplant	☐ Depression	☐ High Blood Pressure	☐ Lymphoma	☐ None
☐ Benign Prostatic Hypertrophy	☐ Diabetes	☐ HIV/AIDS	☐ Prostate cancer	☐ Other

Past Medical History (please check all that apply)

☐ Appendix Removed	☐ Joint replacement: Knee Right, Left, Bilateral	☐ Prostate: Biopsy
☐ Bladder Removed	☐ Joint replacement: Hip Right, Left, Bilateral	☐ Prostate: TURP
☐ Mastectomy: Right, Left, Bilateral	☐ Kidney biopsy	☐ Rectum: Low Anterior Resection
☐ Lumpectomy: Right, Left, Bilateral	☐ Kidney Removed (Nephrectomy)	☐ Skin: Skin Biopsy
☐ Breast Biopsy Right, Left, Bilateral	☐ Kidney Stone Removal	☐ Skin: Basal Cell Carcinoma
☐ Colectomy: Colon Cancer Resection	☐ Kidney Transplant	☐ Skin: Squamous Cell Carcinoma
☐ Colectomy: Diverticulitis	☐ Liver Shunt	☐ Skin: Melanoma
☐ Colectomy: IBD	☐ Liver Transplant	☐ Spleen Removed
☐ Gallbladder Removed	☐ Liver: Hepatectomy	☐ Testicles Removed Right, Left, Bilateral
☐ Coronary Artery Bypass	☐ Ovaries Removed: Endometriosis	☐ Hysterectomy: Fibroids
☐ Cardiac Stent	☐ Ovaries Removed: Cyst	☐ Hysterectomy: Uterine Cancer
☐ Mechanical Valve Replacement	☐ Ovaries Removed: Ovarian Cancer	☐ Hysterectomy: Cervical Cancer
☐ Biologic Valve Replacement	☐ Ovaries: Tubal Ligation	☐ None
☐ Heart Transplant	☐ Pancreas: Pancreatectomy	☐ Other:

Skin Disease History: (please check all that apply)

☐ Acne	☐ Blistering Sunburn	☐ Hay Fever/Allergies	☐ Psoriasis
☐ Actinic Keratosis	☐ Dry Skin	☐ Melanoma	☐ Squamous Cell Skin Cancer
☐ Asthma	☐ Eczema	☐ Poison Ivy	☐ None
☐ Basal Cell Skin Cancer	☐ Flaking or Itchy Scalp	☐ Precancerous Moles	☐ 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?	

Medications: (Please enter all current medications)

Allergies: (Please enter all allergies) _____

Social History: (Please circle all that apply)

Cigarette Smoking:	**Alcohol 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

Alerts (please check all that apply)

☐ Allergy to Lidocaine	☐ Artificial heart valve	☐ Pacemaker	☐ Immunosuppression
☐ Allergy to Adhesive	☐ Artificial joint replacement within past two years	☐ Rapid heartbeat with epinephrine	☐ Anxiety
☐ Allergy to topical antibiotics	☐ Blood thinners	☐ Are you pregnant or trying to get pregnant?	☐ West Africa: Travel or contact
☐ Problems with healing	☐ Defibrillator	☐ Problems with bleeding	
☐ Problems with scarring Hypertrophic or Keloid	☐ MRSA	☐ Hepatitis	

Height: _____ Weight: _____ Date of Birth: _____

Signature: _____ Date _____