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History & Intake Form

Name: _____ Date: _____

Preferred Name: _____ Occupation: _____

What are you here for today? _____

Past Medical History: (please circle all that apply)

Anxiety	Depression	Leukemia
Arthritis	Diabetes	Lung Cancer
Artificial joints	End Stage Renal Disease	Lymphoma
Asthma	GERD	Pacemaker
Atrial fibrillation	Hearing Loss	Prostate Cancer
BPH	Hepatitis	Radiation Treatment
Bone Marrow Transplantation	Hypertension	Seizures
Breast Cancer	HIV/AIDS	Stroke
Colon Cancer	Hypercholesterolemia	Valve Replacement
COPD	Hyperthyroidism	None
Coronary Artery Disease	Hypothyroidism	Other: _____

Past Surgical History: (please circle all that apply)

Appendix Removed	Kidney Removed (Right, Left)
Bladder Removed	Kidney Stone Removal
Mastectomy (Right, Left, Bilateral)	Kidney Transplant
Lumpectomy (Right, Left, Bilateral)	Ovaries Removed: Endometriosis
Breast Biopsy (Right, Left, Bilateral)	Ovaries Removed: Cyst
Breast Reduction	Ovaries Removed: Ovarian Cancer
Breast Implants	Prostate Removed: Prostate Cancer
Colectomy: Colon Cancer Resection	Prostate Biopsy
Colectomy: Diverticulitis	TURP
Colectomy: IBD	Skin Biopsy
Gallbladder Removed	Basal Cell Cancer Surgery
Coronary Artery Bypass	Squamous Cell Carcinoma Surgery
PTCA	Melanoma Surgery
Mechanical Valve Replacement	Spleen Removed
Biological Valve Replacement	Testicles Removed (Right, Left, Bilateral)
Heart Transplant	Hysterectomy: Fibroids
Joint Replacement, Knee (Right, Left, Bilateral)	Hysterectomy: Uterine Cancer
Joint Replacement, Hip (Right, Left, Bilateral)	None
Joint Replacement within last 2 years	Other: _____
Kidney Biopsy	

Female Patient: (please circle)

Pregnant

Breast Feeding

Skin Disease History: (please circle all that apply)

Acne

Eczema

Precancerous Moles

Actinic Keratoses

Flaking or Itchy Scalp

Psoriasis

Basal Cell Skin Cancer

Hay Fever/Allergies

Squamous Cell Skin Cancer

Blistering Sunburns

Melanoma

Dry Skin

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(s)? _____

Any other family history: _____

Medications: (Please enter all current medications)

Allergies: (Please enter all allergies)

Pharmacy: (name and phone number)

Height: _____ **Weight:** _____

Social History: (Please circle all that apply)

Cigarette Smoking:

Never smoked | Quit: former smoker | Smokes daily | Smokes less than daily

Alcohol Use:

Alcohol: none | Alcohol: 1-2 drinks a day | Alcohol: 3 or more drinks a day