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History & Intake Form

Name: ____ Date of Birth: _____________________

Preferred Name: __________________________ Occupation: ________________________________

What are you here for today?____

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease

Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism

Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
None
Other: ________________

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy

Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
None
Other: _____________

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

Flu Vaccine: (Please circle whether you had the vaccine this season)

Yes No