History and Intake Form

Name:_____ **Date of Birth:**_____ **Date**_____

Primary Care Physician:_____ **Preferred Pharmacy:** _____

Past Medical History: (Please check mark all that applies. Please mark "**None**" if nothing applies.)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial joints
- ☐ Asthma
- ☐ Atrial fibrillation (Irregular heartbeat)
- ☐ BPH (Enlarged Prostate)
- ☐ Bone Marrow Transplantation
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD (Emphysema)
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease (Kidney disease)
- ☐ GERD (Acid reflux)
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension (High Blood Pressure)
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia (High Cholesterol)
- ☐ Hyperthyroidism (Thyroid Disease - Fast)
- ☐ Hypothyroidism (Thyroid Disease - Slow)
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Pacemaker
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Valve Replacement (Heart)
- ☐ None

Other:_____

Past Surgical History: (Please check mark all that applies. Please mark "**None**" if nothing applies)

- ☐ Appendix Removed
- ☐ Bladder Removed
- ☐ Mastectomy (Right, Left, Both)
- ☐ Lumpectomy (Right, Left, Both)
- ☐ Breast Biopsy (Right, Left, Both)
- ☐ Breast Reduction
- ☐ Breast Implants
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD (Inflammatory Bowel Disease)
- ☐ Gallbladder Removed
- ☐ Coronary Artery Bypass
- ☐ PTCA (Balloon angioplasty)
- ☐ Mechanical Valve Replacement (Heart)
- ☐ Biological Valve Replacement (Heart)
- ☐ Heart Transplant
- ☐ Joint Replacement, Knee (Right, Left, Both)
- ☐ Joint Replacement, Hip (Right, Left, Both)
- ☐ 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 (Resection of prostate)
- ☐ Skin Biopsy
- ☐ Basal Cell Carcinoma Cancer Surgery
- ☐ Squamous Cell Carcinoma Surgery
- ☐ Melanoma Surgery
- ☐ Spleen Removed
- ☐ Testicles Removed (Right, Left, Both)
- ☐ Hysterectomy: Fibroids
- ☐ Hysterectomy: Uterine Cancer
- ☐ None

Other:_____

Skin Disease History: (Please check mark all that applies. Please mark "**None**" if nothing applies.)

☐ 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
☐ Lupus
☐ None

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 skin cancer?

☐ Basal Cell Carcinoma ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son
☐ Squamous Cell Carcinoma ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son
☐ Melanoma ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son
☐ No

Please list any other family history of diseases:

Mother:_____
Father:_____
Sister:_____
Brother:_____
Daughter:_____
Son:_____

Do you have any allergies **(including drug allergies)** ☐ Yes ☐ No

Please list:

Social History: (Please check mark all that applies.)

Cigarette Smoking:
☐ Never smoked
☐ Former smoker
☐ Smokes less than daily
☐ Smokes daily

Alcohol use:
☐ None
☐ Less than 1 drink per day
☐ 1-2 drinks per day
☐ 3 or more per day

IV Drug Use:
☐ Yes
☐ No

How often do you exercise:
☐ Once a day
☐ A few times a week
☐ A few times a month
☐ Never

Caffeine use:
☐ Once a day
☐ A few times a week
☐ A few times a month
☐ Never

Have you ever been diagnosed or exposed to HIV or AIDS? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No
Do you have artificial joints? ☐ Yes ☐ No
Are you required to take antibiotics before minor surgery? ☐ Yes ☐ No
Do you have hearing aids or are hearing impaired? ☐ Yes ☐ No
Do you have Alzheimer's or Dementia? ☐ Yes ☐ No