

Name: _____ Date of Birth: _____ MR# _____

Primary Care Physician: _____ Phone: _____

Address: _____

History and Intake Form

Past Medical History: (please circle all that apply)

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

Past Surgical History: (please circle all that apply)

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

****PLEASE COMPLETE OTHER SIDE****

Skin Disease History: (please circle all that apply)

Acne

Actinic Keratoses

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

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 Melanoma? Yes No

If yes, which relative(s)? _____

Any other family history: _____

Medications: (Please enter all current medications)
with strength/dose, route & frequency

Drug Allergies: Yes No

Other Allergies:

Social History: (Please circle one)

Cigarette Smoking:

Never smoked

Quit: former smoker

Smokes less than daily

Smokes daily

Pharmacy:

Name: _____

Street: _____

City: _____ State: _____ Zip code: _____

Occupation and Workplace _____

Patient Signature: _____ Date: _____