History and Intake Form

Name: _____Date:_____

Primary Provider Name:_____

Preferred language: _____

Race:

- ☐ White
- ☐ American Indian
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific island islander
- ☐ Other Race

Ethnic Group:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown

Preferred Pharmacy: _____

 # _____

Past Medical History: (please check all that apply)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Bone Marrow Transplantation
- ☐ BPH
- ☐ 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
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ None
- ☐ Other _____

Past Surgical History: (please check 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 (angioplasty)
- ☐ 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 - Prostatectomy
- ☐ Skin Biopsy
- ☐ Basal Cell Cancer Surgery
- ☐ Squamous Cell Carcinoma Surgery

- ☐ 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
- ☐ Other
- ☐ Melanoma Surgery
- ☐ Spleen Removed
- ☐ Testicles Removed (Right, Left, Bilateral)
- ☐ Hysterectomy: Fibroids
- ☐ Hysterectomy: Uterine Cancer
- ☐ None

_____

Skin Disease History: (please check all that apply)

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Other
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ None

_____

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)? _____

Medications: (Please enter all current medications) _

☐ None

_____
_____
_____
_____

Allergies: (Please enter all allergies)

☐ None

_____
_____
_____

Social History: (Please check all that apply)

☐ Not sexually active
☐ Sexually active with one partner
☐ Sexually active with more than one partner
☐ Same gender sex partner
☐ Drug use
☐ IV Drug use
☐ Other _____

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

Occupation: _____

Smoking Status: (Please check all that apply)

☐ **Current every day smoker**
☐ **Current some day smoker**
☐ **Former smoker**

☐ **Never smoked**
☐ **Smoker current status unknown**
☐ **Unknown if ever smoked**

Cautions / Alerts: (Please check all that apply)

☐ Allergy to adhesive: rash
☐ Allergy to Lidocaine: itching
☐ Allergy to Lidocaine: palpitations
☐ Allergy to Lidocaine: sweating
☐ Allergy to topical antibiotic ointments
☐ Artificial heart valve

☐ Defibrillator
☐ MRSA
☐ Pacemaker
☐ Patient vasovagal
☐ Personal history of malignant melanoma
☐ Premedication prior to procedures

- [ ] Artificial joints within past two years
- [ ] Blood thinners
- [ ] Rapid heartbeat with epinephrine
- [ ] Pregnancy or planning a pregnancy

Review of Systems: Are you currently experiencing any of the following? (Please check all that apply)

- [ ] New hair growth on face, chest or abdomen
- [ ] New Moles
- [ ] Problems with bleeding/easy bruising
- [ ] Problems with healing
- [ ] Problems with scarring (hypertrophic or keloid)
- [ ] Rash
- [ ] Sensitivity to sunlight
- [ ] Significant change in existing moles
- [ ] Significant hair loss
- [ ] Significant persistent or intermittent burning of the skin
- [ ] Night sweats
- [ ] Unintentional weight loss
- [ ] Thyroid problems
- [ ] Blurry vision
- [ ] Sore throat
- [ ] Abdominal pain
- [ ] Bloody stool
- [ ] Bloody urine
- [ ] Joint aches
- [ ] Muscle weakness

- [ ] Significant persistent or intermittent itching of the skin
- [ ] Currently having menstrual periods
- [ ] Irregular menstrual cycle
- [ ] Hay fever
- [ ] Immunosuppression
- [ ] Chest Pain
- [ ] Palpitations, irregular heart beat
- [ ] Fever or chills
- [ ] Neck stiffness
- [ ] Headaches
- [ ] Seizures
- [ ] Cough
- [ ] Shortness of breath
- [ ] Wheezing
- [ ] Anxiety
- [ ] Depression