

NAME: _____

History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety	Coronary Artery Disease	Thyroid Problems
Arthritis	Depression	hyper/hypo
Asthma	Diabetes	Leukemia
Atrial fibrillation (irreg heart beat)	End Stage Renal Disease	Lung Cancer
Bone Marrow Transplantation	GERD	Lymphoma
Breast Cancer	Hearing Loss	Prostate Cancer
Colon Cancer	Hepatitis	Radiation Treatment
COPD	High Blood pressure	Seizures
	HIV/AIDS	Stroke
	High Cholesterol	NONE

Other _____

Past Surgical History: (please circle all that apply)

Appendix Removed	Kidney Removed (Right, Left)
Bladder Removed	Kidney Stone Removal
Breast: Mastectomy (Right, Left, Bilateral)	Kidney Transplant
Breast: Lumpectomy (Right, Left, Bilateral)	Liver: Shunt
Breast Biopsy (Right, Left, Bilateral)	Liver: Transplant
Colectomy: Colon Cancer Resection	Liver: Hepatectomy
Colectomy: Diverticulitis	Ovaries Removed: Endometriosis
Colectomy: IBD	Ovaries Removed: Cyst
Gallbladder Removed (cholecystectomy)	Ovaries Removed: Ovarian Cancer
Coronary Artery Bypass	Ovaries: Tubal ligation
Mechanical Valve Replacement	Pancreas removed
Biological Valve Replacement	Prostate Removed: Prostate Cancer
Heart Transplant	Prostate Biopsy
Joint Replacement, Knee (Right, Left, Bilateral)	Rectum: Lower resection
Joint Replacement, Hip (Right, Left, Bilateral)	TURP (Prostate Removal)
	Spleen Removed
	Testicles Removed (Right, Left, Bilateral)
	Hysterectomy: Fibroids
	Hysterectomy: Uterine Cancer
Joint Replacement within last 2 years	NONE
Kidney Biopsy (Nephrectomy)	

Other _____



NAME: _____

Skin Disease History: (please circle all that apply)

- | | | |
|------------------------|------------------------|---------------------------|
| Acne | Dry Skin | Poison Ivy |
| Actinic Keratoses | Eczema | Precancerous Moles |
| Asthma | Flaking or Itchy Scalp | Psoriasis |
| Basal Cell Skin Cancer | Hay Fever/Allergies | Squamous Cell Skin Cancer |
| Blistering Sunburns | Melanoma | |
| | | 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)? _____

Medications: (Please enter all current medications)

Allergies: (Please enter all allergies)

Family History: (Only first degree relatives)

Social History: (Please circle all that apply)

Cigarette Smoking:

- Current ever day smoker
- Current someday smoker
- Former smoker
- Never smoker
- Cigar smoker
- Heavy tobacco smoker
- Light tobacco smoker

Alcohol Use:

- EtOH- None
- EtOH- less than 1 drink per day
- EtOH -1-2 drinks per day
- EtOH -3 or more drinks per day

Other _____

Preferred Language: _____ Race: _____ Ethnic Group: _____

Preferred pharmacy Name: _____ Phone # _____ City or Zip Code _____



NAME: _____

Review of Systems: Are you currently experiencing any of the following?
(Please check yes or no for the following)

Symptom	Yes	No
Problems with bleeding		
Problems with healing		
Problems with scarring		
Rash		
Immunosuppression		
Hay fever		
Shortness of breath		
Joint aches		
Fever or chills		
Night sweats		
Nausea		
Vomiting		
Abdominal pain		
Hair loss		
Headaches		
Eye pain		
Blurry vision		
Bloody urine		
Bloody stool		
Depression		
Unintentional weight loss		
Thyroid problems		
Sore throat		
Muscle weakness		
Chest pain		
Neck stiffness		
Seizures		
Cough		
Wheezing		
Anxiety		

Other Symptoms: _____