HISTORY AND INTAKE FORM

PAST MEDICAL HISTORY: *(please circle all that apply)*

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

Other ____

PAST SURGICAL HISTORY*: (please circle all that apply)*

Appendix Removed	Joint Replacement within last 2 years
Bladder Removed	Kidney Biopsy (Nephrectomy)
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 (Prostate Removal)
Coronary Artery Bypass	Spleen Removed
Mechanical Valve Replacement	Testicles Removed (Right, Left, Bilateral)
Biological Valve Replacement	Hysterectomy: Fibroids
Heart Transplant	Hysterectomy: Uterine Cancer
Joint Replacement, Knee (Right, Left, Bilateral)	
Joint Replacement, Hip (Right, Left, Bilateral)	NONE

Other ____

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)? ____

MEDICATIONS: (*Please enter all current medications)*
____
____
____

ALLERGIES*: (Please enter all allergies)*
____
____
____

SOCIAL HISTORY: *(Please circle all that apply)*

Cigarette Smoking:

Currently Smokes
Has smoked in the past
Never smoked
Former 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____

FAMILY HISTORY *(Only first degree relatives)*

____

____

____

____

Preferred Language: ____________________________

Race:_______________________ Ethnic Group:__________________________

Preferred Pharmacy Name: ____________________________

Phone#: ______________________________

City or Zip code:______________________

REVIEW OF SYSTEMS

Are you currently experiencing any of the following? *(please circle if yes)*

Problems with bleeding
Problems with healing
Problems with scarring (keloids)
Rash
Blistering sunburns before puberty
Irregular menses
Fever or chills
Immunosuppression
Hay Fever
Chest pain
Night sweats
Unintentional weight loss
Thyroid problems
Sore throat

Bloody stool
Bloody urine
Joint aches
Muscle weakness
Neck stiffness
Headaches
Seizures
Cough
Shortness of breath
Wheezing
Anxiety
Depression
Blurry vision
Abdominal pain

ALERTS : *(please circle all that apply)*

Allergy to Adhesive
Allergy to Lidocaine
Allergy to topical antibiotics
Artificial joint replacement
Blood thinners
Defibrillator

MRSA
Pacemaker
Require antibiotics before procedures
Rapid heartbeat with epinephrine
Are you pregnant or currently trying to get pregnant