Patient name_____**Date of Service**_____

History and Intake Form

Past Medical History: (please circle all that apply) ☐ **NONE**

Anxiety
Arthritis
Asthma
Atrial fibrillation
'Bone Marrow Transplantation'
'Benign Prostatic Hyperplasia'
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
High Blood pressure
HIV/AIDS
High Cholesterol
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke

Other _____

Past Surgical History: (please circle all that apply) ☐ **NONE**

Appendix Removed
Bladder Removed
Breast Biopsy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Mastectomy (Right, Left, Bilateral)
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Colon: Colostomy Gallbladder Removed Biological Valve Replacement Coronary Artery Bypass Heart Transplant Mechanical Valve Replacement
Heart: PTCA
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement, Knee (Right, Left, Bilateral)
Kidney Biopsy
Kidney Stone Removal
Kidney Transplant
Kidney Removed (Right, Left)
Liver Removed
Liver Transplant
Liver shunt surgery
Ovaries Removed: Endometriosis
Ovaries Removed: Ovarian Cancer
Ovaries Removed: Cyst
Ovaries: Tubal Ligation
Pancreas Removed
Prostate Biopsy
Prostate Removed: Prostate Cancer
TURP (Prostate Removal)
Rectum: Abdominal Perineal Resection
Rectum: Lower Anterior Resection
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
Hysterectomy: Uterine Cancer

Other _____

Skin Disease History: (please circle all that apply) □ **NONE**

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

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) □ Check here if you have no known drug allergies

Drug allergy:	**Drug reaction:**

Social History: (Please check all that apply)

Cigarette Smoking:
☐ Currently Smokes
☐ Has smoked in the past
☐ Never smoked
☐ Former Smoker

Occupation: _____

Family History: Do any of your first degree relatives have any of the following conditions:

A first-degree relative is defined as a close blood relative which includes parents, full siblings, or children

Medical Condition:	First degree relative:
☐ Asthma	_____
☐ Congenital Heart disease	_____
☐ Diabetes	_____
☐ Migraines	_____
☐ Stroke	_____
☐ Psoriasis	_____

If the office should need to contact you regarding test results, how would you like to be notified?
Preferred Phone #: _____ Home/Work/Mobile (circle one)

☐ Do not leave messages ☐ Ok to leave a message with results

Preferred Language:_____Race:_____Ethnic Group: _____

Preferred pharmacy Name: _____

Phone#:_____ City or Zip code: _____

ALERTS: (please circle or check all that apply)

Personal history of Melanoma? ☐ Yes ☐ No
Are you pregnant or currently trying to get pregnant? ☐ Yes ☐No
Require premedication prior to a surgical procedure? ☐ Yes ☐No

Allergy to Adhesive
Allergy to Lidocaine
Allergy to Topical Antibiotics
Artificial heart valve
Artificial joint replacement-
(-within 2 years)
Defibrillator
Blood thinners
Pacemaker
Rapid heartbeat with epinephrine
MRSA

Review of Systems: Are you *currently* experiencing any of the following?
(Circle for yes, leave blank for no)

Allergic/Immunologic:
Asthma or Hayfever

Constitutional:
Excessive fatigue
Fever or chills

Endocrine:
Unintentional weight loss

Eyes:
Blurry vision

Gastrointestinal
Abdominal pain
GI upset

Hematologic/ Lymphatic:
Swollen lymph nodes
Swelling of hands or feet

Musculoskeletal:
Back pain
Joint aches

Neurological:
Headache

Psychiatric:
Anxiety
Depression