HISTORY AND INTAKE

Patient name_____**Date of Service**_____

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

Acute Hepatitis
Anxiety disorder
Arthritis
Asthma
Atrial fibrillation
COPD
Coronary heart disease
Depression
Diabetes mellitis
Disease caused by Covid 19
Elevated blood pressure
End stage kidney disease
Epilepsy
GERD
History of hypertension
Hearing loss
HIV infection
High cholesterol
Hyperthyroidism
Hypothyroidism
Inflammatory disease of liver
Leukemia
Malignant tumor:
☐ lymphoma
☐ of lung
☐ of breast
☐ of colon
☐ of prostate
Radiation therapy treatment
Stroke
Transplantation of bone marrow
Other: _____

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

Coronary angioplasty
Coronary artery bypass graft
Entire transplanted kidney
Excision of:
☐ Basal cell carcinoma
☐ Melanoma
☐ Squamous cell carcinoma
History of colectomy
History of mastectomy
Hysterectomy
Mechanical heart valve replaced
Splenectomy
Total nephrectomy
Total replacement of:
☐ Left hip joint
☐ Left knee joint
☐ Right hip joint
☐ Right knee joint
Transplantation of heart
Transplantation of liver
Other: _____

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

Acne
Actinic keratoses
Basal cell carcinoma of skin
Contact dermatitis from poison ivy
Dysplastic nevus of skin
Eczema
History of asthma
History of hay fever
Malignant **Melanoma-**
Date/Location: _____
Psoriasis
Squamous Cell Skin Cancer
Sunburn of second degree
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-include dosages and supplement names)*

☐ **Check here if you consent for us to import your RX history** ☐ **NONE**

_____
_____
_____

HISTORY AND INTAKE

Allergies: *(Please enter all allergies)* ☐ **Check here if you have no known drug allergies**

Drug allergy:	Drug reaction:

What is your Smoking Status? ☐ Unknown
☐ Current every day smoker ☐ Current some day smoker (cigar) ☐ Current some day smoker (cigarette)
☐ Former smoker ☐ Never smoker
☐ Cigar smoker ☐ Heavy tobacco smoker ☐ Light tobacco smoker

How many times in the past year you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women or any adult older than 65?
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9

Do you consume alcohol?
☐ None ☐ Less than 1 drink per day ☐ 1-2 drinks per day ☐ 3 or more drinks per day

Occupation: _____

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 pharmacy Name: _____

Phone#:_____ City or Zip code: _____

☐ **Please activate my patient portal via my email address-** You will receive an email with instructions on how to set your own password. The email link will expire in 72 hours.

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)
Blood thinners
Defibrillator
MRSA
Pacemaker
Rapid heartbeat with epinephrine