HISTORY AND INTAKE

Patient name_____**Date of Service**_____

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, Both)
Lumpectomy (Right, Left, Both)
Mastectomy (Right, Left, Both)
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 Replace, Hip (Right, Left, Both)
Joint Replace, Knee (Right, Left, Both)
Kidney Biopsy
Kidney Stone Removal
Kidney Transplant
Kidney Removed
Liver Removed
Liver Transplant
Liver shunt surgery
Ovaries Removed: Endometriosis
Ovaries Removed: Ovarian Cancer
Ovaries Removed: Ovarian 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
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
Hysterectomy: Cervical Cancer

Other: _____

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

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

Skin History Continued:

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)? _____

HISTORY AND INTAKE

Medications: *(Please enter all current medications-include dosages and supplement names)*

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

_____

_____

_____

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

Drug allergy:	Drug reaction:

Cigarette Smoking: ☐ Current ☐ Former ☐ Never

Occupation: _____

Family History: Do any of your immediate family members have any of the following conditions:
Immediate family is defined as a close blood relative which includes parents, full siblings, or children

Medical Condition:
- ☐ Asthma
- ☐ Congenital Heart disease
- ☐ Diabetes
- ☐ Migraines
- ☐ Stroke
- ☐ Psoriasis

Immediate Family Member:
_____
_____
_____
_____
_____
_____

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: _____

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)*

Asthma
Excessive fatigue
Fever or chills
Unintentional weight loss
Blurry vision
Abdominal pain
GI upset
Swollen Lymph nodes
Swelling of hands or feet
Back pain
Joint aches
Headache
Anxiety
Depression