History and Intake Form

Patient Name: _____ Date of Birth: _____

Address: _____

Home # _____ Cell # _____ Work # _____

Email: _____

In case of Emergency, who should be notified?_____ Phone # _____

Past Medical History: (please circle all that apply)

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

Other: _____

Past Surgical History: (please circle all that apply)

Coronary Artery Bypass	Joint Replacement, Hip (Right, Left, Bilateral)
Mechanical Valve Replacement	Joint Replacement within last 2 years
Biological Valve Replacement	Kidney Transplant
Heart Transplant	NONE
Joint Replacement, Knee (Right, Left, Bilateral)	

Other: _____

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 _____

PLEASE SEE OTHER SIDE

Reason for Visit: _____

Do you wear Sunscreen? Yes No
If yes, what SPF? _____

Do you tan in a tanning salon? Yes No

Family Skin Disease History: (please circle all that apply, SPECIFY IF OTHER)

Melanoma	Mother	Father	Sister	Brother	Daughter	Son	Other
Non-Melanoma Skin Cancer	Mother	Father	Sister	Brother	Daughter	Son	Other

Do you live in a Nursing Home, Assisted Living, or Retirement Home? Yes No

Medications: (please enter all current medications and dosages)

_____
_____
_____
_____

Allergies: (please enter all allergies)

_____
_____
_____
_____

Pharmacy Name: _____
Street: _____ Zip Code: _____
Primary Care Physician: _____
Employer: _____
Occupation: _____ Field of Work: _____
Place of Birth: _____