History and Intake Form

Patient Name: _____ Date of Birth: _____

Address: _____

Home Phone # _____ Cell Phone # _____ Work Phone # _____

Email: _____

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone Marrow Transplantation
BPH
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
Thyroid Problems [Hyper or Hypo]
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Pacemaker
NONE

Other: _____

Past Surgical History: (please circle all that apply)

Coronary Artery Bypass
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Transplant
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: _____

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 and Vitamins: (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: _____