History & Intake Form Name:_____ Date: _____

Cell Phone #:_____ Home Phone #:_____ Primary Care Physician: _____

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial Fibulation
Bone Marrow Transplant
Breast Cancer
Colon Cancer
COPD
Coronary Heart Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation treatment
Seizures
Stroke
NONE
Other_____
_____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Breast : Breast Biopsy
Lumpectomy (R, L, Both Breasts)
Mastectomy (R, L, Both Breasts)
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: Inflammatory Bowel Disease
Colon Removed
Gallbladder Removed
Heart: Mechanical Valve Replacement
Heart: Coronary Artery Bypass Surgery
Heart Transplant
Heart Stent
Joint Replacement : Hip (R, L, Both)
Joint Replacement : Knee (R, L, Both)
Kidney : Kidney Biopsy
Kidney : Kidney Stone Removal
Kidney Removed
Liver surgery
Ovaries Removed: Endometriosis
Ovaries Removed: Ovarian Cancer
Ovaries Removed: Ovarian Cyst
Pancreas Removed
Prostate Biopsy
Prostate Removed
Rectal Surgery
Spleen Removed
Testicles Removed
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
Hysterectomy: Cervical Cancer
NONE
Other _____
_____

Skin Disease History: (please circle all that apply):

Melanoma
Squamous Cell Carcinoma
Basal Cell Carcinoma
Actinic Keratoses
Atypical Moles
Acne
Blistering Sunburns
Dry Skin
Eczema
Excessive Sweating
Flaking or Itchy Scalp
Hay Fever/Allergies
Psoriasis
NONE
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 **blood** relative? _____

Medications: (please list all current medications):

Name of Rx	Strength & Form (ex. 10 mg tablet)	How many times per day?

PLEASE CONTINUE INTAKE ON BACK

Drug Allergies: (please list all known drug allergies AND reaction)

_____ _____
_____ _____
_____ _____

Social History: (please circle all that apply)

Cigarette Smoking:	**Alcohol use:**	**Women:** How many times in the past year have you had 4 or more drinks in a day? _____ **Men:** How many times in the past year have you had 5 or more drinks in a day? _____ **over 65:** How many times in the past year have you had 4 or more drinks in a day? _____
Currently smokes Former smoker Has smoked in the past Never smoker	NONE less than 1 drink per day 1-2 drinks per day 3 or more drinks per day	

If over 19, have you had a flu shot this flu season? Y / N When?_____ Last DT (tetnus) shot: _____	If over 50, have you received the shingles (herpes zoster) vaccine? Y / N	If over 65, did you receive the pneumonia vaccine? Y / N

Please list any family health history in first degree relatives only (non-skin related): _____

_____

Pharmacy Information: Preferred Pharmacy:_____

Phone #: _____ City or Zip Code: _____

Review of Systems: Are you currently experiencing any of the following? (Please circle yes or no)

Are you experiencing an itch?	Y / N
On a scale of 0 – 10, 10 being the worse, how would you rate the itch? ____	
chest pain	Y / N
cough or shortness of breath	Y / N
gastrointenstinal issues including diarrhea or bloody stool	Y / N
headaches or seizures	Y / N
immunosupression	Y / N
autoimmune arthritis (i.e. rheumatoid) or other autoimmune disorder (lupus)	Y / N
fever or chills	Y / N
rash	Y / N
thyroid problems	Y / N
sore throat	Y / N
visual changes	Y / N
joint aches	Y / N
depression	Y / N

Alerts: (please circle yes or no for the following)

artificial heart valve	Y / N	bleeding or clotting issues (blood thinners)	Y / N
allergy to lidocaine	Y / N	pregnant or planning a pregnancy	Y / N
rapid heart beat with epinephrine	Y / N	premedication prior to procedures	Y / N
defibrillator or pacemaker	Y / N	recent travel outside of the country	Y / N