History and Intake Form

Name: _____ **Date:** _____

Primary Care Doctor's Name: _____

Preferred language: _____

Race:

- ☐ White
- ☐ American Indian
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific island islander
- ☐ Other Race

Ethnic Group:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown

Preferred Pharmacy: _____

_____

Past Medical History: (please check 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
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ None
- ☐ Other _____

Past Surgical History: (please check all that apply)

- ☐ Appendix Removed
- ☐ Bladder Removed
- ☐ Mastectomy (Right, Left, Bilateral)
- ☐ Lumpectomy (Right, Left, Bilateral
- ☐ Breast Biopsy (Right, Left, Bilateral)
- ☐ Breast Reduction
- ☐ Breast Implants
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Gallbladder Removed
- ☐ Coronary Artery Bypass
- ☐ PTCA (angioplasty)
- ☐ Kidney Biopsy
- ☐ Kidney Removed (Right, Left)
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Ovaries Removed: Endometriosis
- ☐ Ovaries Removed: Cyst
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Prostate Removed: Prostate Cancer
- ☐ Prostate Biopsy
- ☐ TURP - Prostatectomy
- ☐ Skin Biopsy
- ☐ Basal Cell Cancer Surgery
- ☐ Squamous Cell Carcinoma Surgery

- ☐ 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
- ☐ Other
- ☐ Melanoma Surgery
- ☐ Spleen Removed
- ☐ Testicles Removed (Right, Left, Bilateral)
- ☐ Hysterectomy: Fibroids
- ☐ Hysterectomy: Uterine Cancer
- ☐ None

_____

Skin Disease History: (please check all that apply)

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ 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 _____

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) _

☐ None

_____

_____

_____

_____

Allergies: (Please enter all allergies)

☐ None

_____

_____

_____

Social History: (Please check all that apply)

☐ Drug use
☐ IV Drug use
☐ Other
☐ Alcohol consumption: None
☐ Other

☐ Alcohol consumption: Less than 1 drink per day
☐ Alcohol consumption: 1-2 drinks per day
☐ Alcohol consumption: 3 or more drinks per day
☐ None

Occupation: _____

Smoking Status: (Please check all that apply)

☐ **Current every day smoker**
☐ **Current some day smoker**
☐ **Former smoker**
☐ **Never smoked**
☐ **Smoker current status unknown**
☐ **Unknown if ever smoked**

Cautions / Alerts: (Please check all that apply)

☐ Allergy to adhesive: rash
☐ Allergy to Lidocaine: itching
☐ Allergy to Lidocaine: palpitations
☐ Allergy to Lidocaine: sweating
☐ Allergy to topical antibiotic ointments
☐ Artificial heart valve
☐ Artificial joints within past two years
☐ Blood thinners
☐ Defibrillator
☐ MRSA
☐ Pacemaker
☐ Patient vasovagal
☐ Personal history of malignant melanoma
☐ Premedication prior to procedures
☐ Rapid heartbeat with epinephrine
☐ Pregnancy or planning a pregnancy

Review of Systems: Are you currently experiencing any of the following?
(Please check all that apply)

- ☐ New hair growth on face, chest or abdomen
- ☐ New Moles
- ☐ Problems with bleeding/easy bruising
- ☐ Problems with healing
- ☐ Problems with scarring (hypertrophic or keloid)
- ☐ Rash
- ☐ Sensitivity to sunlight
- ☐ Significant change in existing moles
- ☐ Significant hair loss
- ☐ Significant persistent or intermittent burning of the skin
- ☐ Significant persistent or intermittent itching of the skin
- ☐ Currently having menstrual periods
- ☐ Irregular menstrual cycle
- ☐ Hay fever
- ☐ Immunosuppression
- ☐ Chest Pain
- ☐ Palpitations, irregular heart beat
- ☐ Fever or chills
- ☐ Night sweats
- ☐ Unintentional weight loss
- ☐ Thyroid problems
- ☐ Blurry vision
- ☐ Sore throat
- ☐ Abdominal pain
- ☐ Bloody stool
- ☐ Bloody urine
- ☐ Joint aches
- ☐ Muscle weakness
- ☐ Neck stiffness
- ☐ Headaches
- ☐ Seizures
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Anxiety
- ☐ Depression