Intake and History Form

Name: _____ Date: _____

Street Address: _____ City/ State: _____

Zip Code: _____ Date of Birth: _____ Gender: _____

Home phone number: _____Cell phone number: _____

Email address: _____Emergency contact: _____

Preferred Language: _____Race: _____Ethnic group: _____

Preferred Pharmacy:

Name: _____Phone number: _____

Address: _____

Past Medical History:

Select any of the following medical conditions you currently have:

_____Anxiety	_____Diabetes	____Lung Cancer
_____Arthritis	_____End Stage Renal Disease	____Lymphoma
_____Asthma	_____GERD	_____Prostate Cancer
_____Atrial Fibrillation	_____Hearing Loss	_____Radiation Treatment
_____Bone Marrow Transplant	_____Hepatitis	_____Seizures
_____BPH	_____Hypertension	_____Stroke
_____Breast Cancer	_____HIV/AIDS	_____NONE
_____Colon Cancer	_____Hypercholesterolemia	_____Other
_____COPD	_____Hyperthyroidism	_____
_____Coronary Artery Disease	_____Hypothyroidism	_____
_____Depression	_____Leukemia	_____

Intake and History Form

Past Surgical History:

Have you had any surgeries on the following organs?

_____Appendix (Appendectomy)

_____Bladder (Cystectomy)

_____Breast: Breast Biopsy

_____Breast:Lumpectomy(Right, Left, Bilateral)

_____Breast:Mastectomy(Right, Left, Bilateral)

_____Colon (Colectomy): Colon CA Resection

_____Colon: Colostomy

_____Gallbladder (Cholecystectomy)

_____Heart: Coronary Artery Bypass

_____Heart: Heart Transplant

_____Heart: Mechanical Valve Replacement

_____Heart: PTCA

_____Joint Replacement:Hip(Right, Left, Bilateral)

_____Joint Replacement:Knee(Right, Left, Bilateral)

_____Kidney: Kidney Biopsy

_____Kidney: Kidney Stone Removal

_____Kidney: Kidney Transplant

_____Kidney: Nephrectomy

_____Liver: Liver Transplant

_____Liver: Shunt

_____Ovaries (Oophorectomy): Endometriosis

_____Ovaries (Oophorectomy): Ovarian Cancer

_____Ovaries (Oophorectomy): Ovarian Cyst

_____Ovaries: Tubal Ligation

_____Pancreas: Pancreatectomy

_____Prostate (Prostatectomy):Prostate CA

_____Rectum: APR

_____Rectum: Low Anterior Resection

_____Skin: Basal Cell Carcinoma

_____Skin: Melanoma

_____Skin: Skin Biopsy

_____Skin: Squamous Cell Carcinoma

_____Spleen (Splenectomy)

_____Testicles (Orchiectomy)

_____Uterus(Hysterectomy): Fibroids

_____Uterus (Hysterectomy): Uterine Cancer

_____Uterus (Hysterectomy): Cervical Cancer

_____NONE

_____Other

_____

_____

_____

Intake and History Form

Skin Disease History:

Have you had any of the following?

_____Acne

_____Actinic Keratosis

_____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

_____

_____

Do you have a family history of Melanoma?

_____Yes ____No

If yes, which relative?

_____Mother

_____Father

_____Sister

_____Brother

_____Daughter

_____Son

_____Uncle

_____Aunt

_____Nephew

_____Niece

_____Grandmother

_____Grandfather

_____Grandson

_____Granddaughter

_____Other

_____

_____

Do you wear Sunscreen?

_____Yes _____No

If yes, what SPF? _____

Do you tan in a tanning salon?

_____Yes _____No

Intake and History Form

Occupation and Workplace:

_____

_____

Place of Residence:

_____

_____

Skin History:

Have you ever visited a Dermatologist? _____Yes _____No When? _____

Reason? _____ Treatment? _____

When you are exposed to the sun do you: _____Tan Only _____Tan & Burn _____Burn

Would you describe your CURRENT (within the last 2 years) sun exposure history as?

_____ Minimal _____Moderate _____Maximal

Would you describe your childhood (pre-age 18) sun exposure as?

_____ Minimal _____Moderate _____Maximal

Allergies to medications _____

List all oral and topical medications you are currently taking or applying.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Intake and History Form

Social History

Smoking Status (please choose one):

_____ Current every day smoker

_____Current someday smoker

_____Former smoker

_____ Never smoker

Date started smoking: _____

Date quit smoking: _____

Number of packs per day: _____

Total years smoking: _____

Alcohol Intake (please choose one):

_____ None

_____1 or less per day

_____ 1-2 per day

_____ 3 or more per day

Driving Status:

_____ Drive in the daytime

_____ Drive at night

How often do you exercise?

_____Several times a day

_____ Once a day

_____ A few Times a week

_____A few times a month

_____ Never

Other: _____

What is your caffeine use?

_____ Several times a day

_____Once a day

_____A few times a week

_____ A few times a month

_____ Never

Other: _____