History and Intake Form

Past Medical History: (please mark all that apply)

☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Atrial fibrillation
☐ Bone Marrow Transplant
☐ BPH
☐ Breast Cancer
☐ (BRCA2 +) _____
☐ Colon Cancer
Cancer: Other
_____
☐ COPD
☐ Coronary Artery Disease
☐ Depression
☐ Diabetes
☐ Renal Disease
☐ GERD
☐ Hay Fever
☐ Hearing Loss
☐ Hepatitis
☐ High Blood pressure
☐ HIV/AIDS
☐ High Cholesterol
Thyroid Problems:
☐ Hyper / ☐ Hypo
☐ Leukemia
☐ Lung Cancer
☐ Lupus
☐ Lymphoma
☐ MS
☐ Prostate Cancer
☐ Radiation Treatment
☐ Seizures
☐ Stroke
☐ Pacemaker
History of Tuberculosis:
_____

Other _____

Past Surgical History: (please list all)

_____
_____

Skin Disease History: (please mark all that apply)

☐ Acne
☐ Actinic Keratoses
☐ Basal Cell Skin Cancer
☐ Blistering Sunburns
☐ Dry Skin
☐ Eczema
☐ Flaking or Itchy Scalp
☐ Melanoma
☐ MRSA
☐ Poison Ivy
☐ Precancerous Moles
☐ Psoriasis
☐ Rosacea
☐ Squamous Cell Skin Cancer:
_____

Other _____

Please circle the following responses:

Family history of Melanoma: ☐ Mother ☐ Father ☐ Sister ☐ Brother
☐ Daughter ☐ Son Other Family member: _____

Do you tan in a tanning salon? ☐ YES ☐ NO
History of tanning bed use +10 times? ☐ YES ☐ NO
Do you get your Flu Vaccine? ☐ YES ☐ NO
Did you get your pneumococcal vaccine? (65 and older)? ☐ YES ☐ NO

Medications: (Please enter all current medications)

_____
_____
_____

Allergies: (Please enter all allergies)

_____
_____
_____

Social History:
_____
_____
_____

Cigarette Smoking:
☐ Never Smoked
☐ Quit: Former Smoker
☐ Smokes Daily

Do you drink Alcohol? ☐ YES ☐ NO

Pharmacy Name:_____

Street:_____ Zip code:_____

Referring Physician:_____

Phone Number: _____ Fax Number:_____

Patient name_____

(please print)

Patient DOB _____