History and Intake Form

Patient Name:_____ **DOB:** _____

Primary Physician:_____ **Phone Number:** _____

Pharmacy Name: _____ **Phone Number:** _____

Past Medical History: (please check 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
- ⬭ NONE

Other:

_____

_____

Height: _____ **Weight:** _____

Past Surgical History: (please list most recent surgeries- less than 5 years)

_____

_____

Skin Disease History: (please check all that apply)

- ⬭ Acne
- ⬭ Actinic Keratoses
- ⬭ Alopecia
- ⬭ Basal Cell Skin Cancer
- ⬭ Blistering Sunburns
- ⬭ Eczema
- ⬭ Melanoma
- ⬭ Poison Ivy
- ⬭ Precancerous Moles
- ⬭ Psoriasis
- ⬭ Rosacea
- ⬭ Squamous Cell Skin Cancer
- ⬭ Vitiligo
- ⬭ Warts (Verruca Vulgaris)
- ⬭ OTHER: _____

Family history of Melanoma: ⬭ Mother ⬭ Father ⬭ Sister ⬭ Brother ⬭ Daughter ⬭ Son

Family history of: ⬭ Basal Cell Carcinoma/⬭ Squamous Cell Carcinoma: _____(whom)

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

If you are 65 and older did you get your pneumococcal vaccine? ⬭ YES ⬭ NO

Medications: (Please list all current medications)

_____ _____ _____

_____ _____ _____

_____ _____

Allergies: (Please list any allergies to Medications)

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_____ _____ _____ _____
_____

Cigarette Smoking: ⬭Never Smoked ⬭Quit: Former Smoker ⬭Daily Smoker

Do you drink Alcohol? ⬭YES ⬭NO

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