

# Intake and History Form

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Name: \_\_\_\_\_

Street Address: \_\_\_\_\_ City / State: \_\_\_\_\_

Zip Code: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Phone Number (day): \_\_\_\_\_ Phone Number (night): \_\_\_\_\_

Email Address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Preferred Language: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnic Group: \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_ Referred by: \_\_\_\_\_

## Preferred Pharmacy

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Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

City or Zip Code: \_\_\_\_\_

## Past Medical History

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Select any of the following medical conditions you currently have:

- Anxiety Disorder
- Arthritis
- Asthma
- Atrial Fibrillation
- Benign prostatic hyperplasia
- Cerebrovascular accident
- Chronic obstructive lung disease
- Coronary arteriosclerosis
- Depressive disorder
- Diabetes mellitus
- Disease caused by 2019-nCoV

- Elevated blood pressure
- End-stage renal disease
- Epilepsy
- Gastroesophageal reflux disease
- Hearing Loss
- H/O Hypertension
- Hypercholesterolemia
- Hyperthyroidism
- Hypothyroidism
- Inflammatory Disease of Liver
- Leukemia

- Malignant Lymphoma
- Malignant tumor of lung/breast/colon (which one)
- Malignant tumor of Prostate
- Radiation Therapy
- Transplantation of bone marrow
- NONE
- Other

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# Intake and History Form

## Past Surgical History

Have you had any surgeries on the following organs?

- Abdominoperineal resection (APR)
- Bilateral replacement of knee joints
- Biopsy of breast
- Biopsy of prostate
- Coronary artery bypass graft
- Entire transplanted kidney
- Excision of basal cell carcinoma
- Excision of melanoma
- Excision of squamous cell carcinoma
- H/O: Colostomy
- H/O: Tubal ligation
- History of appendectomy
- History of bilateral mastectomy
- History of cholecystectomy
- History of colectomy
- History of liver excision
- History of percutaneous transluminal coronary angioplasty
- History of tissue graft heart valve replacement
- History of total cystectomy
- History of transurethral prostatectomy
- Hysterectomy
- Kidney biopsy
- Low anterior resection of rectum

- Lumpectomy of breast
- Lumpectomy of left breast
- Lumpectomy of right breast
- Mastectomy of left breast
- Mastectomy of right breast
- Mechanical heart valve replacement
- Oophorectomy
- Pancreatectomy
- Percutaneous extraction of kidney stone
- Portosystemic shunt operation
- Prostatectomy
- Prosthetic arthroplasty of bilateral hips
- Splenectomy
- surgical biopsy of skin
- Total nephrectomy
- Total orchidectomy
- Total replacement of left hip joint
- Total replacement of right hip joint
- Total replacement of left knee joint
- Total replacement of right knee joint
- Transplantation of heart
- Transplantation of liver
- None
- Other:

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# Intake and History Form

## Skin Disease History

Have you had any of the following?

- Acne
  - Actinic Keratosis
  - Asteatosis cutis
  - Basal Cell Skin Cancer
  - Contact dermatitis due to poison ivy
  - Dysplastic nevus
  - Eczema
  - History of asthma
  - History of Hay Fever
  - Malignant Melanoma
  - Pruritus of scalp
  - Psoriasis
  - Squamous Cell Skin Cancer
  - Sunburn of second degree
  - NONE
  - Other
- 
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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?

- Mother
  - Father
  - Sister
  - Brother
  - Daughter
  - Son
  - Uncle
  - Aunt
  - Nephew
  - Niece
  - Grandmother
  - Grandfather
  - Grandson
  - Granddaughter
  - Other
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# Intake and History Form

## Medications

List all current medications include dosage and frequency:

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## Allergies

List all allergies and reactions if known:

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## Social History

### Smoking Status (please choose one):

- Current everyday smoker
- Current someday smoker
- Former smoker
- Never smoker
- Unknown if ever smoked

Start Smoking:

- mm/dd/yyyy \_\_\_\_\_

Quit Smoking:

- mm/dd/yyyy \_\_\_\_\_

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:

- Drives in the Daytime
- Drives at Night

### How often do you exercise?

- Unspecified
- Several times a day
- Once a day
- A few times a week
- A few times a month
- Never
- Other \_\_\_\_\_

### What is your caffeine use?

- Unspecified
- Several times a day
- Once a day
- A few times a week
- A few times a month
- Never
- Other \_\_\_\_\_

# Intake and History Form

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Pneumonia vaccination  YES  NO

Do you have a health care proxy?  YES  NO

Designee's name \_\_\_\_\_ Designee's phone number \_\_\_\_\_

Do you have a Living will?  YES  NO

## Review of Systems

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Please check yes or no for the following:

Symptom	Yes	No
Allergy to adhesive – rash		
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		
Palpitations, irregular heart beat		
Unintentional weight loss		
Thyroid problems		
Joint aches		
Anxiety		
Depression		

# Intake and History Form

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## Alerts

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Please check yes or no for the following:

Symptom	Yes	No
Allergy to lidocaine – itching		
Allergy to lidocaine – palpitations		
Allergy to lidocaine – sweating		
Allergy to topical antibiotic ointments		
Allergy to – latex		
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 pregnancy		