INTAKE FORM

NAME: _____ DOB: _____ Date: _____**20/____**

Language: _____ Ethnicity: _____ (Caucasian, Africa American, Pacific Islander, Asain etc.)

History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
BPH (Benign prostatic hyperplasia
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD (Emphysema)
Coronary Artery disease
Depression
Diabetes
End Stage Renal Disease
GERD (Acid Reflux)
OTHER: _____

Hearing loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholestrolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lymphoma
Prostate Cancer
Radiation treatment
Seizures
Stroke
None

Past Surgical History: (please circle 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
Gallbladder Removed
Coronary Artery Bypass
PTCA (Angioplasty)
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:

Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removed
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate biopsy
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma
Melanoma Surgery
Spleen removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine cancer
None

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratosis
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Other:_____

Hay Fever/ Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
None

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)? _____
Any other family history of skin cancer:_____

Medications: (Please list all current medications)

_____
_____
_____

Allergies to Medication: (Please list all allergies and type of reaction, ex., rash, hives, breathing problems)

_____
_____

Alcohol Use:
None less than 1 drink/ day 1-2 drinks/day 3+ drinks/day
Cigarette Smoking:
Everyday Social Former None

Name of Referring Doctor: _____ **Phone** #: _____

Pharmacy:
Name: _____ Phone: _____
Street: _____ Zip code: _____

REVIEW OF SYMPTOMS	
Problems with bleeding	Yes/ No
Problems with healing	Yes/ No
Problems with scarring (hypertrophic or keloid)	Yes/ No
Rash	Yes/ No

ALERTS (please circle all that apply)	MRSA (methicillin resistant staph aureus infections)
Allergy to adhesive	Pacemaker
Allergy to lidocaine	Pre-medication prior to procedures
Allergy to topical antibiotic ointments	Rapid heart rate with epinephrine
Artificial heart valve	Pregnancy or planning a pregnancy
Artificial joints within past two years	HIV positive
Blood thinners	Hepatitis B or C
Defibrillator	Organ Transplant