HISTORY AND INTAKE FORM

NAME: ____ **DATE OF BIRTH:** ________________

Past Medical History (please circle all that apply)

Anxiety	Depression	Leukemia
Arthritis	Diabetes	Lung Cancer
Artificial joints	End Stage Renal Disease	Lymphoma
Asthma	GERD (Acid reflux)	Pacemaker
Atrial fibrillation	Hearing Loss	Prostate Cancer
BPH (Benign Prostatic Hyperplasia)	Hepatitis	Radiation Treatment
Bone Marrow Transplantation	Hypertension	Seizures
Breast Cancer	HIV/AIDS	Stroke
Colon Cancer	Hypercholesterolemia	Valve Replacement
COPD (Emphysema)	Hyperthyroidism	None
Coronary Artery Disease	Hypothyroidism	

Other:____

Past Surgical History (please circle all that apply)

Appendix Removed	Heart Valve Replacement	Lung Transplant
Basal Cell Cancer Surgery	Heart Transplant	Melanoma Surgery
Bladder Removed	Hysterectomy	Ovaries Removed: Endometriosis
Mastectomy (Right, Left, Both)	Joint Replacement, Shoulder (Right Left, Both)	Ovaries Removed: Cyst
Lumpectomy (Right, Left, Both)	Joint Replacement, Knee (Right, Left, Both)	Ovaries Removed: Ovarian Cancer
Breast Biopsy (Right, Left, Both)	Joint Replacement, Hip (Right, Left, Both)	Prostate Removed: Prostate Cancer
Breast Reduction	Kidney Biopsy	Prostate Biopsy
Breast Implants	Kidney Removed (Right, Left)	Spleen Removed
Colectomy: Colon Cancer Resection	Kidney Stone Removal	Squamous Cell Carcinoma Surgery
Colectomy: Diverticulitis	Kidney Transplant	Testicles Removed (Right, Left, Both)
Colectomy: IBD	Liver Transplant	Tonsillectomy
Gallbladder Removed		TURP
Coronary Artery Bypass		Skin Biopsy
Heart Stent		None

Other:____

Skin Disease History (please circle all that apply)

Acne	Other
Actinic Keratoses	Hay Fever/ Allergies
Asthma	Hives
Basal Cell Skin Cancer	Melanoma
Blistering Sunburns	Poison Ivy
Chicken Pox	Precancerous Moles
Dry Skin	Psoriasis
Eczema	Squamous Cell Cancer
Flaking or Itchy Scalp	

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?

____

Please enter all current medications and non-prescription medications.

Medications	Dosage	Frequency

Drug Allergies (please enter all allergies and type of reaction)

____

____

____

____

Social History (please circle one)

Cigarette Smoking:

Never smoked

Quit: (former smoker)

Smokes less than daily

Smokeless tobacco

Other:________________

Alcohol Use:

Yes

No

Ethnicity:

Hispanic/ Latino

Non-Hispanic Latino

Language:

English

Spanish

Race:

White

Black/ African American

Asian

American Indian or Native Alaskan

Native Hawaiian/ Pacific Islander

Other:______________________________________

Pharmacy:

Name:____

City & Zip:____

Do you have any of the following:

1. Latex allergy
2. HIV positive
3. Hepatitis
4. Allergy to lidocaine
5. Allergy to topical antibiotic ointments
6. Artificial heart valve
7. Artificial joints within past six months
8. Blood thinners
9. Defibrillator
10. MRSA
11. Pacemaker
12. Premedication prior to procedures
13. Rapid heart beat with epinephrine
14. Pregnancy or planning a pregnancy
15. Problems with bleeding
16. Problems with healing
17. Problems with scarring
18. Rash
19. Sun sensitivity
20. Immunosuppression
21. Hay fever