**HISTORY AND INTAKE FORM**

**Today’s Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Full Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Last) (First) (M.I)

**Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason for todays visit:**

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

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

**Past Medical History:** (Circle all that apply)

Acne

Actinic Keratosis

Anxiety

Arthritis

Asthma

Atrial Fibrillation

Basal Cell Carcinoma

Breast Cancer

Colon Cancer

COPD

Coronary Artery Disease

Depression

Diabetes

Dysplasic Nevus

Eczema

GERD

Hearing Loss

Hepatitis

High Blood Pressure

High Cholesterol

HIVS/AIDS

Leukemia

Lung Cancer

Lymphoma

Malignant Melanoma

Merkel Cell Carcinoma

Prostate Cancer

Psoriasis

Radiation Treatment

Renal Disease

Seborrheic Dermatitis

Seizures

Skin Cancer

Stroke

Squamous Cell Carcinoma

Thyroid Disfunction

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Surgical History:** (Circle all that apply)

Appendectomy

Biopsy of skin

Cesarean Section

Cholecystectomy

Hysterectomy

Implantation of cardiac defibrillator

Joint Replacement

Mastectomy

Oophorectomy

Operation of skin

Organ Replacement

Organ Transplant

Thyroidectomy

TURP

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal Skin History:**

|  |  |  |
| --- | --- | --- |
|  | Location(s) and Year(s) | Treatment(s) |
| Actinic Keratosis |  |  |
| Basal Cell Carcinoma |  |  |
| Dysplastic Moles |  |  |
| Malignant Melanoma |  |  |
| Squamous Cell Carcinoma |  |  |

Do you wear sunscreen? Yes No

Do you have a history of blistering sunburns? Yes No

Do you tan in a tanning salon? Yes No

Do you have a family history of non-melanoma skin cancers? Yes No

Do you have a family history of melanoma? Yes No

**Medications:** (Please enter all current medications and supplements.)

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

**Drug Allergies:**

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

**Social History:**

Are you a smoker? Yes No Never

If so, amount per day: \_\_\_\_\_\_\_

Do you drink alcohol? Yes No Never

If so, amount per day: \_\_\_\_\_\_\_

Do you ever use drugs? (Marijuana included) Yes No Never

Are you pregnant or breastfeeding? Yes No

Do you plan on becoming pregnant? Yes No

If so, when: \_\_\_\_\_\_\_

**Review of Systems:** (Please check yes or no for the following.)

|  |  |  |
| --- | --- | --- |
|  | Yes | No |
| Abdominal Pain |  |  |
| Headaches |  |  |
| Coughing |  |  |
| Fever or Chills |  |  |
| Shortness of Breath |  |  |
| Anxiety or Depression |  |  |
| Unexplained Weightloss |  |  |
| Joint Pain |  |  |

**Primary Care Physician:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Preferred Pharmacy:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Race/Ethnicity:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Preferred Language:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_