Patient Name______________________________ Date:___________________________

History and Intake Form

Past Medical History: (please circle all that apply)

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

Other ____

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
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA
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
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
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 Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
None

Other ____

Patient Name_______________________________ Date:____________________________

Skin Disease History: (please circle all that apply)

Acne	Eczema	Psoriasis
Actinic Keratosis	Flaking or Itchy Scalp	Squamous Cell Skin Cancer
Asthma	Hay Fever/Allergies	None
Basal Cell Skin Cancer	Melanoma	
Blistering Sunburns	Poison Ivy	
Dry Skin	Precancerous Moles	

Other ____

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)? ____

Medications: (Please enter all current medications)

____
____
____

Allergies: (Please enter all allergies)

____
____
____

Social History: (Please circle all that apply)

Currently Smokes - daily	Has never smoked
Currently Smokes - not daily	Drug Use
Has smoked in the past	None

Other____

Preferred Language:____

Race:____

Ethnicity:____

Pharmacy: Where can we send prescriptions?_____________________________
____

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Patient Name_____________________________ Date:___________________________

Review of Systems: Are you currently experiencing any of the following? (please check yes or no for the following)

Symptom	*Yes*	*No*
Pacemaker		
Defibrillator		
Artificial joints within past two years		
Artificial heart valve		
Premedication prior to procedures		
Allergy to adhesive		
Allergy to topical antibiotic ointments		
Blood thinners		
Pregnancy or planning a pregnancy		
Allergy to lidocaine		
Rapid heartbeat with epinephrine		
Yeast infection with antibiotics		
GI upset with antibiotics		
Problems with bleeding		
Problems with healing		
Problems with scarring		
Immenosuppession		
Changing mole		
Rash		
Hayfever		

Other Symptoms: ____

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