Name:_____ **Date of Birth:**_____ **Dr.**_____

History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation (a-fib)
BPH (Benign Prostatic Hyperplasia)
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
CORD (Emphysema)
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD (Acid reflux)
Hearing Loss
Hepatitis A
Hepatitis B
Hepatitis C
Hypertention
HIV/ AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement

None

Other:_____

Today's problem list:_____

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: 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)
Kidney Biopsy
Kidney Removed
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Biopsy
Prostate Removed: Prostate Cancer
TURP
Skin Biopsy
Basal Cell Skin Cancer Surgery
Squamous Cell Skin Cancer Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer

None

Other:_____

Have you received your Flu vaccine? Yes No

Patients 55yrs+ Have you received your Shingles Vaccine? Yes No

Patients 65yrs+ Have you received your Pneumonia Vaccine? Yes No

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Atypical Nevi
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay fever/ Allergies
Herpes
Melanoma In Situ
Melanoma
MRSA
Poison Ivy
Precancerous Moles
Psoriasis
Rosacea
Shingles
Squamous Cell Skin Cancer
STAPH

None

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)?_____

Any other primary family medical history

_____

Current medications:

_____

Pharmacy Name:_____

_____

_____

_____

Current Allergies:

_____

_____

_____

_____

Social History: (please circle all that apply)

Smoking status:
Never smoked
Quit: former smoker
Smokes daily
Smokes occasionally (tobacco)
Smokes occasionally (cigarette)
Cigar smoker

Alcohol Use:
No
Yes (occasionally)
Yes (daily)

Preferred Language:
English
French
Spanish
Other: _____

Race:
White
Black/ African American
Asian
American Indian or Native Alaskan
Native Hawaiian/ Pacific Islander

Ethnicity:
Hispanic/ Latino
Non-Hispanic/ Latino

For future prescriptions:

Address:_____

_____