Medical History and Intake Form

Patient Name: ____ Date of Birth _____/______/_______
Reason for visit: ____
Person filling out form (if different from patient): ____

Past Medical History: (please circle all that apply)

Anxiety	Depression	Thyroid Problems: (Hyper or Hypo)
Arthritis	Diabetes	Leukemia
Asthma	End Stage Renal Disease	Lung Cancer
Atrial fibrillation	GERD	Lymphoma
Bone Marrow Transplantation	Hearing Loss	Prostate Cancer
BPH	Heart Failure	Radiation Treatment
Breast Cancer	Hepatitis	Seizures
Colon Cancer	High Blood pressure	Stroke
COPD	HIV/AIDS	Pacemaker
Coronary Artery Disease	High Cholesterol	
Other ____________________		

Past Surgical History: (please list all)

__________________________ __________________________ __________________________
__________________________ __________________________ __________________________

Skin Disease History: (please circle all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratoses	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Squamous cell skin cancer
Blistering Sunburns	Melanoma	
Other_____________________		

Melanoma Family History: Mother Father Sister Brother Daughter Son Other

Do you wear Sunscreen? Yes/ No If yes, what SPF? _____
Do you tan in a tanning salon? Yes/ No/Previously Used

Medications: (Please enter all current medications)

__________________________ __________________________ __________________________
__________________________ __________________________ __________________________
__________________________ __________________________ __________________________
__________________________ __________________________ __________________________

Allergies (please list):

__________________________ __________________________ __________________________

(Over →)

Patient Name: ____ Date of Birth _____/______/_______

Social History: (please circle all that apply)
Cigarette Smoking/Tobacco Use: Never/ Quit: Former Use/ Current use less than daily/ Daily use
Alcohol: None/ Less than 1 drink a day/ 1-2 drinks per day/ 3 or more drinks per day
IV or Illicit drug use: None/ Current/ Former/ Please Specify: ____

Pharmacy Name:____ Phone: ___________________________________
Street:____ Zip code: _________________________________

Primary Care Provider: ____
Referring Physician: (if applicable**)**_________________________ Fax: _____________________________________

Do you have an Advanced Directive (living will)? Yes/ No

Immunizations? Have you received the following vaccines? If so, When?
Flu ? Y/ N ______________
Shingles? Y/N ___________
Pneumcoccal pneumonia? Y/N ______

Symptoms: (Please circle any that you are currently experiencing)

Problems with bleeding	Bloody stool	Hay fever
Problems with healing	Bloody urine	Joint aches
Keloid/ hypertrophic scars	Blurry vision	Muscle weakness
Immunosuppression	Chest pain	Night sweats
Changing mole(s)	Cough	Shortness of breath
Rash	Depression	Sore throat
Abdominal pain	Fever or chills	Weight loss
Anxiety	Headaches	Wheezing

Alerts: (please mark)
Y/N Do you require pre-medication prior to procedures or dental work ?
Y/N Allergy to adhesive?
Y/N Allergy to topical antibiotics?
Y/N Do you take blood thinners?
Y/N Pregnant or planning pregnancy?
Y/N Breastfeeding?
Y/N Allergy to lidocaine?
Y/N Rapid heartbeat with epinephrine?
Y/N Yeast infections with antibiotics?
Y/N GI upset with antibiotics?

May we leave a message regarding your results or care?
Y/N home phone? _________________________________ Y/N cell phone? _______________________________
Y/N Other person? (name/ relationship) ____

Signature: ____

Reviewed by: ____ Date: _____________________