Patient Name:______________________________ **DOB:**____________ **Date:**____________

History and Intake Form

Past Medical History: (please circle all that apply)

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

Past Surgical History:
None
List Surgeries:
____
____
____
____
____
____
____

Skin Disease History: (please circle all that apply)

Asthma
Dry Skin
Eczema
Flaking or Itchy Scalp
Psoriasis
Actinic Keratoses
Basal Cell Skin Cancer
Melanoma
Precancerous Moles
Squamous Cell Skin Cancer
None

Other ______________________________

Do you wear Sunscreen? Yes No
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:
(attach list if there is not enough space below)

Dosage & Frequency:

Drug Allergies: (Please enter all medication allergies)

Do you have a pacemaker?	Yes	No	Are you pregnant?	Yes	No
Do you have a defibrillator?	Yes	No	Are you breastfeeding?	Yes	No

Social History: (Please circle all that apply)

Tobacco Use:

- Never used tobacco
- Quit: former tobacco user
- Uses tobacco less than daily
- Uses tobacco daily

Illicit Drug Use:

- Drug Use
- IV Drug Use
- No Drug Use

Alcohol Use:

- Alcohol: none
- Alcohol: less than 1 drink a day
- Alcohol: 1-2 drinks a day
- Alcohol: 3 or more drinks a day

Your Preferred Local Pharmacy:______________________________

Reason for Today's Visit: