PATIENT HISTORY AND INTAKE

NAME_____ DATE OF BIRTH_____

PAST MEDICAL HISTORY
(Select all conditions you currently have or have had in the past)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation (Irregular Heartbeat)
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End State Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Other_____

PAST SURGICAL HISTORY
(Select all surgeries you have had)

- ☐ Appendectomy
- ☐ Bladder Cystectomy
- ☐ Breast: Biopsy Left/Right (circle which)
- ☐ Breast: Lumpectomy Left/Right(circle which)
- ☐ Breast: Mastectomy Left/Right(circle which)
- ☐ Colon (Colectomy): Cancer Resection
- ☐ Colon (Colectomy): Diverticulitis
- ☐ Colon (Colectomy): Inflammatory Bowel Disease)
- ☐ Colon: Colostomy
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Biological Valve Replacement
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Joint Replacement: Hip Left/Right (circle which)
- ☐ Joint Replacement: Knee Left/Right (circle which)
- ☐ Kidney Biopsy
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Kidney: Nephrectomy
- ☐ Liver Transplant
- ☐ Liver Shunt
- ☐ Ovaries (Oophorectomy): Endometriosis
- ☐ Ovaries (Oophorectomy): Ovarian Cancer
- ☐ Ovaries (Oophorectomy): Ovarian Cyst
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreatectomy
- ☐ Prostate Biopsy
- ☐ Prostate Cancer
- ☐ Prostatectomy: TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Splenectomy
- ☐ Testicles (Orchiectomy)
- ☐ Uterus (Hysterectomy): Fibroids
- ☐ Uterus (Hysterectomy): Uterine Cancer
- ☐ Uterus (Hysterectomy): Cervical Cancer
- ☐ Other _____

THIS IS A 2 PAGE FORM; PLEASE COMPLETE THE OTHER SIDE

HISTORY AND INTAKE FORM

NAME_____ DATE OF BIRTH_____

SKIN DISEASE HISTORY
(Select all you have had)

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Asthma
- ☐ Basal Cell Carcinoma
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Carcinoma
- ☐ Other_____

SKIN DISEASE FAMILY HISTORY

Has anyone in your family been diagnosed with Melanoma? ☐ YES ☐ NO If YES, which relative?_____

MEDICATIONS

(List all medications and dosages including Over-The-Counter, supplements, and herbal remedies OR provide a list with this form)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

ALLERGIES
(List all medications to which you have had an allergic reaction)

_____ _____

_____ _____

SOCIAL HISTORY

Do you currently smoke? ☐ YES ☐ NO
If YES, how many packs per day? _ If NO, have you smoked in the past? ☐ YES ☐ NO

Do you drink alcohol? ☐ YES ☐ NO If YES, how many drinks per day? ___

What is your occupation? _____