

HISTORY AND INTAKE FORM

NAME _____

DATE OF BIRTH _____

PAST MEDICAL HISTORY

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

- | | |
|--|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Hearing Loss |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Atrial Fibrillation (Irregular Heartbeat) | <input type="checkbox"/> HIV / AIDS |
| <input type="checkbox"/> Bone Marrow Transplant | <input type="checkbox"/> Hypercholesterolemia |
| <input type="checkbox"/> BPH (Benign Prostate Hyperplasia) | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Lung Cancer |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> GERD | <input type="checkbox"/> Stroke |
| | <input type="checkbox"/> Other _____ |

PAST SURGICAL HISTORY

(Select all surgeries you have had)

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

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)

- | | |
|---|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Hay Fever/Allergies |
| <input type="checkbox"/> Actinic Keratoses | <input type="checkbox"/> Melanoma |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Poison Ivy |
| <input type="checkbox"/> Basal Cell Carcinoma | <input type="checkbox"/> Precancerous Moles |
| <input type="checkbox"/> Blistering Sunburns | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Squamous Cell Carcinoma |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Flaking or Itchy Scalp | |

FAMILY HISTORY of MELANOMA

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

MEDICATIONS – PLEASE CHOOSE ONE OPTION

I have given my consent on a separate form for Pioneer Valley Dermatology to electronically import my medications and have also listed over-the-counter medicines and supplements below. **IF YOU CHOOSE THIS OPTION PLEASE SIGN THE SEPARATE CONSENT FORM IN THIS PACKET.**

OR CHOOSE ONE OF THE OPTIONS BELOW AND DO NOT SIGN THE CONSENT FORM

- I have listed below all my current medications and dosages, including over-the-counter, supplements and herbal remedies.
- I have provided a list of all my current medications.

_____	_____
_____	_____
_____	_____
_____	_____

ALLERGIES

(List all medications to which you have had an allergic reaction OR check the box below)

I am not allergic to any medications

_____	_____
_____	_____

SOCIAL HISTORY

Do you currently smoke? YES NO If NO have you ever been a smoker? YES NO

How many times in the past year have you had more than 4 alcoholic drinks in a single day? _____

What is your occupation? _____