

History and Intake Form

NAME: _____ **DATE:** _____

Primary Doctor: _____ **Referring Doctor:** _____

Past Medical History: (please circle all that apply)

Anxiety	Hepatitis
Arthritis	Hypertension
Artificial joints	HIV/AIDS
Asthma	Hypercholesterolemia
Atrial fibrillation	Hyperthyroidism
BPH (Benign Prostatic Hyperplasia)	Hypothyroidism
Bone Marrow Transplantation	Leukemia
Breast Cancer	Lung Cancer
Colon Cancer	Lymphoma
COPD (Emphysema)	Pacemaker
Coronary Artery Disease	Prostate Cancer
Depression	Radiation Treatment
Diabetes	Seizures
End Stage Renal Disease	Stroke
GERD (Acid reflux)	Valve Replacement
Hearing Loss	None
Other _____	

Past Surgical History: (please circle all that apply)

Appendix Removed	Kidney Biopsy
Bladder Removed	Kidney Removed (Right, Left)
Mastectomy (Right, Left, Bilateral)	Kidney Stone Removal
Lumpectomy (Right, Left, Bilateral)	Kidney Transplant
Breast Biopsy (Right, Left, Bilateral)	Ovaries Removed: Endometriosis
Breast Reduction	Ovaries Removed: Cyst
Breast Implants	Ovaries Removed: Ovarian Cancer
Colectomy: Colon Cancer Resection	Prostate Removed: Prostate Cancer
Colectomy: Diverticulitis	Prostate Biopsy
Colectomy: IBD	TURP
Gallbladder Removed	Skin Biopsy
Coronary Artery Bypass	Basal Cell Cancer Surgery
PTCA	Squamous Cell Carcinoma Surgery
Mechanical Valve Replacement	Melanoma Surgery
Biological Valve Replacement	Spleen Removed
Heart Transplant	Testicles Removed (Right, Left, Bilateral)
Joint Replacement, Knee (Right, Left, Bilateral)	Hysterectomy: Fibroids
Joint Replacement, Hip (Right, Left, Bilateral)	Hysterectomy: Uterine Cancer
Joint Replacement within last 2 years	None
Other _____	

**Please
Turn
Over!**
Thank you

Skin Disease History: (please circle all that apply)

Acne	Hay Fever/Allergies
Actinic Keratosis	Melanoma
Asthma	Poison Ivy
Basal Cell Skin Cancer	Precancerous Moles
Blistering Sunburns	Psoriasis
Dry Skin	Squamous Cell Skin Cancer
Eczema	None
Flaking or Itchy Scalp	
Other _____	

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____
Any other family history: _____

Medications: (Please enter all current medications)

Allergies: (Please enter all allergies)

Social History: (Please circle one)

Cigarette Smoking:

Never smoked
Quit: former smoker
Smokes less than daily
Smokes daily

Language:

English
Spanish
Other: _____

Race:

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

Ethnicity:

Hispanic/Latino
Non-Hispanic/Latino

Pharmacy:

Name: _____ Telephone Number: _____

Street: _____ Zip code: _____