NAME _____ **DATE** _____

REASON FOR VISIT: _____

HISTORY AND INTAKE FORM

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone Marrow Transplantation
BPH
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Other:_____
None

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Breast Biopsy
Breast: Lumpectomy (Both)
Breast: Lumpectomy (Right)
Breast: Lumpectomy (Left)
Breast: Mastectomy (Both)
Breast: Mastectomy (Left)
Breast: Mastectomy (Right)
Colon: Colon Cancer Resection
Colon: Diverticulitis
Colon: IBD
Colon: Colostomy
Gallbladder Removed
Heart: Biologic Valve Replacement
Heart: Coronary Artery Bypass
Heart: Heart Transplant
Heart: Mechanical Valve Replacement
Heart: PTCA
Joint Replacement: Hip (Both)
Joint Replacement: Hip (Left)
Joint Replacement: Hip (Right)
Joint Replacement: Knee (Both)
Joint Replacement: Knee (Left)
Joint Replacement: Knee (Right)
Kidney: Biopsy
Kidney: Stone Removal
Kidney: Transplant
Kidney: Nephrectomy
Liver: Hepatectomy
LIver: Liver Transplant
Liver: Shunt
Ovaries Removed: Endometriosis
Ovaries Removed: Ovarian Cancer
Ovaries Removed: Ovarian Cyst
Ovaries: Tubal Ligation
Pancreas: Pancreatectomy
Prostate: Biopsy
Prostate: Removed
Prostate: TURP
Rectum: APR
Rectum: Low Anterior Resection
Skin: Basal Cell Cancer Surgery
Skin: Melanoma
Skin: Skin Biopsy
Skin: Squamous Cell Carcinoma
Spleen: Removed
Testicles: Removed
Uterus: Fibroids
Uterus: Uterine Cancer
Uterus: Cervical Cancer

Other: _____
None

Skin Disease History: (please circle all that apply)

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

Do you wear Sunscreen? Yes___No___
If yes, what SPF? _____
Do you tan in a tanning salon? Yes___No___

Do you have a family history of Melanoma? Yes___No___
If yes, which relative(s) have had Melanoma? _____

Medications, Vitamins, Supplements and any Over The Counter Medicines: (please list all current medications or circle none) None

_____
_____
_____
_____

Allergies: (please list all allergies or circle none) None

_____
_____

Social History: (please circle all that apply)

Tobacco/Cigarette Smoking:
- Smoker: some day
- Smoker: everyday
- Former Smoker
- Never Smoker

Illicit Drug Use:
- Drug Use
- IV Drug Use

Sexual History:
- Not sexually active
- Sexually active with one partner
- Sexually active with more than one partner
- Same sex partner

Alcohol Use:
- None
- Less than 1 drink a day
- 1-2 drinks a day
- 3 or more drinks a day

Safety:
- I feel safe at home
- I do not feel safe at home

Other _____

Quality Measures:

Vaccination:
Pneumonia Vaccine: Yes___ No___
Flu Vaccine: Yes___ No___
Advance Care Planning:
Health Care Proxy: Yes___ No___
Living Will: Yes___ No___

Pharmacy: _____
Primary Care Physician: _____

Review of Systems/Alerts: (please circle all that apply)

Allergy to Lidocaine

Pacemaker

Defibrillator

Deep Brain Stimulator

Blood Thinners

History of Stroke

History of Heart Attack

History of Pulmonary Embolism

Immunosuppression

Allergy to adhesive

Allergy to topical antibiotic ointments

Use Vicryl sutures, cannot tolerate PDS sutures

Rapid heartbeat with epinephrine

Pregnancy or planning a pregnancy

Breast feeding

Yeast infections with antibiotics

GI upset with antibiotics

Artificial heart valve

Premedication prior to procedures

Problems with bleeding

Artificial joints within the past two years

Problems with healing

Problems with scarring (hypertrophic or keloid)

Changing mole

Rash

Anxiety

Melanoma

Allergy to Latex

None of the above apply