NAME _____ **DATE** _____

PREFERRED PRONOUNS _____

REASON FOR VISIT: _____

_____

HISTORY AND INTAKE FORM

Past Medical History: (Please circle all that apply)

Anxiety	Hepatitis
Arthritis	Hypertension
Artificial joints	HIV/AIDS
Asthma	Hypercholesterolemia
Atrial fibrillation	Hyperthyroidism
BPH	Hypothyroidism
Bone Marrow Transplantation	Leukemia
Breast Cancer	Lung Cancer
Colon Cancer	Lymphoma
COPD	Pacemaker
Coronary Artery Disease	Prostate Cancer
Depression	Radiation Treatment
Diabetes	Seizures
End Stage Renal Disease	Stroke
GERD	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 _____

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
None
Other _____

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)? _____
Any other family history: _____

Have you had a Pneumovac vaccine? Yes No
Have you had a flu vaccine this past season? Yes No

Medications: (please enter all current medications)

_____
_____
_____

Vitamins, Supplements and over the counter medicines: (list all)

_____
_____

Allergies: (Please enter all allergies) None

_____
_____
_____

Social History: (Please circle all that apply)

Cigarette Smoking:
- Never smoked
- Quit: former smoker
- Smokes less than daily
- Smokes daily

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

Illicit Drug Use:
- Drug Use
- IV Drug Use

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 _____

Pharmacy: _____
Primary Care Physician: _____

Review of Systems: (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

None of the above apply