

PATIENT HISTORY AND INTAKE FORM

Date: _____ Full Name: _____ Date of Birth: _____

Past Medical History: (please circle all that apply)

| | | |
|--|-------------------------|-----------------------------|
| Arthritis | End Stage Renal Disease | Hypothyroid or Hyperthyroid |
| Asthma | (Kidney Disease) | Leukemia |
| Atrial fibrillation | Hepatitis (A / B / C) | Lymphoma |
| Breast Cancer | High Blood pressure | Radiation Treatment |
| Coronary Artery Disease (Heart Disease) | HIV/AIDS | Seizures |
| Diabetes | High Cholesterol | Stroke |
| | | NONE |

Other (circle all that apply or list below):

Autoimmune Disorders Bleeding Disorders Cold Sores on Lips Keloid Formation Scleroderma

Past Surgical History:

Skin Disease History: (please circle all that apply)

| | | |
|------------------------|--------------------|---------------------------|
| Basal Cell Skin Cancer | Melanoma | Squamous Cell Skin Cancer |
| Blistering Sunburns | Precancerous Moles | Actinic Keratosis |
| NONE | | |

Do you wear Sunscreen? Yes No
Do you tan in a tanning salon? Yes No Previous
Do you have a family history of skin cancer (basal cell, squamous cell, melanoma)? Yes No
If yes, which relative(s)? _____

Medications: (Please enter all current medications)

Allergies: (Please enter all allergies)

Height: _____ Weight: _____

Social History: (Please circle all that apply)

Cigarette Smoking: now previously never Alcohol Use: none # of drinks a day: _____

For patients 65 and older: Have you received a pneumonia vaccination? Yes No

Please complete back side of this form →

Family History of any Medical Conditions (Only first-degree relatives):

Preferred Language: _____ Race: _____ Ethnic Group: _____
(Requirements of the Healthcare Reform Law)

Preferred Pharmacy: _____ Phone#: _____ City or Zip code: _____

Primary Care Physician: _____ Referring Physician: _____

Review of Systems: Are you currently experiencing any of the following? (Please check yes or no for the following)

| Symptom | Yes | No | Symptom | Yes | No |
|--------------|-----|----|---------------------|-----|----|
| Weight loss | | | Shortness of breath | | |
| Depression | | | Chest pain | | |
| Muscle aches | | | Easy bruising | | |
| Joint pain | | | Blood clots | | |
| Fever | | | Swollen lymph nodes | | |

Other Symptoms:

ALERTS: (please circle all that apply)

- Allergy to Adhesive or latex
- Allergy to local anesthetics
- Allergy to topical antibiotics
- Artificial heart valve
- Artificial joint replacement
- Blood thinners
- Defibrillator
- MRSA
- Pacemaker
- Require antibiotics prior to a dental or surgical procedure
- Rapid heartbeat with epinephrine
- Are you pregnant or currently trying to get pregnant?
- Are you currently breastfeeding?