History and Intake Form

Name_____

Date of Birth _____ Visit _____

Email _____

(office use only)

Past Medical History: (please circle all that apply)

Anxiety	Depression	Leukemia
Arthritis	Diabetes	Lung Cancer
Asthma	End Stage Renal Disease	Lymphoma
Atrial fibrillation	GERD	Prostate Cancer
Bone Marrow Transplantation	Hearing Loss	Radiation Treatment
BPH	Hepatitis	Seizures
Breast Cancer	High Blood pressure	Stroke
Colon Cancer	HIV/AIDS	Pacemaker
COPD	High Cholesterol	
Coronary Artery Disease	Thyroid Problems (Hyper or Hypo)	NONE

Other

_____

Past Surgical History: (please list all)

_____
_____
_____
_____
_____
_____

Skin Disease History: (please circle all that apply)

Acne	Dry Skin	Psoriasis
Actinic Keratoses	Eczema	Squamous Cell Skin Cancer
Basal Cell Skin Cancer	Flaking or Itchy Scalp	
Blistering Sunburns	Melanoma	
Poison Ivy		NONE
	Precancerous Moles	

Other

_____

Melanoma Mother Father Sister Brother Daughter Son Other

Do you wear Sunscreen? Yes No
If yes, what SPF? _____

Do you tan in a tanning salon? Yes No

Is it ok to leave a detailed message on your voice mail? (ex. Biopsy results) Yes No

If yes, what phone number do you prefer to receive messages:
_____

I give permission for medical results and information to be released to the following:

_____Relationship_____
_____

_____Relationship_____
_____

Signature:_____
_____

Medications: (Please enter all current medications)
_____
_____
_____
_____
_____
_____

Medication/Drug Allergies: (Please enter all allergies)
_____
_____
_____
_____
___

Social History: (Please circle all that apply)

Cigarette Smoking:
Never Smoked
Quit: Former Smoker
Smokes Less Than Daily
Smokes Daily

Preferred Language:
English
Spanish
Other:_____

Race:
White
Black/African American
Asian
American Indian or Native Alaskan
Native Hawaiian/Pacific Islander
Other:_____

Ethnic Group:
Hispanic/Latino
Non-Hispanic/Latino

Pharmacy Name:_____

Street:_____ Zip code:_____

Referring/Primary Physician:_____

Fax Number:_____