History and Intake Form

Name: Soc. Sec. #: Date:

Date of Birth: Sex: Age:

Occupation:

Referred by Dr.: Family Physician, Dr.:

Preferred phone number: ______________________ May we leave a detailed message: ☐ Yes ☐ No

Required by Federal Government

Preferred Language: ___________________________

Race: ☐ African American ☐ Alaska Native ☐ American Indian ☐ Asian
☐ Native Hawaiian ☐ Pacific Islander ☐ White ☐ Other Race
☐ Declined to Specify

Ethnic Group: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Declined to Specify (REQUIRED)

Preferred pharmacy Name: ___________________________________

Street:___________________________

City: _________________

May we obtain your medication history from other providers? ☐ Yes ☐ No

State briefly the problem(s) for which you were referred here:

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
Epilepsy
GERD
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
High Cholesterol
Leukemia
Lung Cancer
Lymphoma
Menstrual Problems
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Thyroid Problems
Tuberculosis (TB)
Weight Change

NONE

Past Surgical History: (please circle all that apply)

Appendectomy
Kidney Transplant
Coronary Artery Bypass
Splenectomy
Liver Transplant
Skin Biopsy
None
Colectomy

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

Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? ______________________________________

Medications: (Please enter all current medications)

____
____
____

Medication Allergies: (Please enter all allergies)

____
____
____

Social History: (Please circle all that apply)

Cigarette Smoking:
Never Smoked
Currently Smokes
Former Smoker

Alcohol Use:
EtOH- None
EtOH- less than 1 drink per day
EtOH -1-2 drinks per day
EtOH -3 or more drinks per day

Family History (only include Father, Mother, Brother or Sister)

Please indicate which family member has a history of the condition by circling.

Diabetes Type 1: Father/Mother/Brother/Sister
Hypertension: Father/Mother/Brother/Sister
Stroke: Father/Mother/Brother/Sister
Blood Disease: Father/Mother/Brother/Sister
Rheumatoid Arthritis: Father/Mother/Brother/Sister

Diabetes Type 2: Father/Mother/Brother/Sister
Tuberculosis: Father/Mother/Brother/Sister
Cancer: Father/Mother/Brother/Sister

ALERTS: (please circle all that apply)

Allergy to Adhesive
Allergy to lidocaine
Allergy to topical antibiotics

Artificial Heart Valve
Artificial joint
Blood thinners

Defibrillator
MRSA
Pacemaker

Pregnant
Currently trying to conceive