**HISTORY AND INTAKE FORM**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Major Cross Streets and/or Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State: \_\_\_\_\_\_\_\_\_\_\_\_

Medicare Part B: Yes / No Pneumonia Vaccination: Yes / No Influenza Vaccination: Yes / No

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| **MEDICAL HISTORY (please circle all that apply)** | | | |
| Anxiety | Depression | | Hypothyroidism *(Low)* |
| Arthritis | Diabetes | | Leukemia |
| Asthma | End Stage Renal Disease | | Lung Cancer |
| Atrial Fibrillation | GERD *(Reflux Disease)* | | Lymphoma |
| Bone Marrow Transplantation | Hearing Loss | | Prostate Cancer |
| Benign Prostatic Hypertrophy | Hepatitis | | Radiation Treatment |
| Breast Cancer | Hypertension *(High Blood Pressure)* | | Seizures |
| Colon Cancer | HIV/AIDS | | Stroke |
| COPD | Hypercholesterolemia | |  |
| Coronary Artery Disease | Hyperthyroidism *(High)* | | **NONE** |
| Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **SURGICAL HISTORY (please circle all that apply)** | | | |
| Appendix Removed | Joint Replacement, Hip | | Prostate Removed: Prostate Cancer |
| Bladder Removed | (Right, Left, Both) | | Prostate: TURP |
| Breast Biopsy | Joint Replacement, Knee | | Skin: Basal Cell Cancer Surgery |
| Lumpectomy (Right, Left, Both) | (Right, Left, Both) | | Skin: Melanoma Surgery |
| Mastectomy (Right, Left, Both) | Kidney Biopsy | | Skin Biopsy |
| Colectomy: Colon Cancer Resection | Kidney Stone Removed | | Skin: Squamous Cell Cancer Surgery |
| Colectomy: Diverticulitis | Kidney Transplant | | Spleen Removed |
| Colectomy: IBD | Kidney Removed (Right, Left) | | Testicles Removed |
| Colostomy | Ovaries: Endometriosis | | Hysterectomy: Fibroids |
| Gallbladder Removed | Ovaries: Ovarian Cancer | | Hysterectomy: Uterine Cancer |
| Heart: Biological Valve Replacement | Ovaries: Ovarian Cyst | | Hysterectomy: Cervical Cancer |
| Heart: Coronary Artery Bypass | Ovaries: Tubal Ligation | |  |
| Heart: Heart Transplant | Pancreas: Pancreatectomy | |  |
| Heart: Mechanical Valve Replacement | Prostate Biopsy | | **NONE** |
| Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **SKIN DISEASE HISTORY (please circle all that apply)** | | | |
| Acne | Eczema | | Psoriasis |
| Actinic Keratoses | Flaking or Itchy Scalp | | Squamous Cell Skin Cancer |
| Asthma | Hay Fever/Allergies | |  |
| Basal Cell Skin Cancer | Melanoma | |  |
| Blistering Sunburns | Poison Ivy | |  |
| Dry Skin | Precancerous Moles | | **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)?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ***Continued on Back 🡪*** | | | |
| **MEDICATIONS & SUPPLEMENTS (If you do not know the name, enter condition and a question mark next to it.)** | | | |
| □ I do not take medications and/or supplements. | | | |
| 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | 7. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | 8. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | 9. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | 10. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | 11. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | 12. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

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| **MEDICATION ALLERGIES / REACTION** | |
| □ No known Allergies. | |
| 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **SOCIAL HISTORY (please circle all that apply)** | |
| **Smoking Status**: | **How often do you exercise?** |
| Never smoker | Never |
| Former smoker | Several times a day |
| Current smoker: □Cigarettes □Cigars | Once a day |
| ● How many packs per day? **\_\_\_\_\_\_\_\_\_** | A few times a week |
| ● How many years smoking? **\_\_\_\_\_\_\_\_\_** | A few times a month |
|  |  |
| **Alcohol Use**: | **Caffeine Use**: |
| Alcohol: None | Never |
| Alcohol: Less than 1 drink per day | Once a day |
| Alcohol: 1-2 drinks per day | Several times a day |
| Alcohol: 3 or more drinks per day | A few times a week |
|  | A few times a month |
| □ **Retired** □ **Student** □ **Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |