**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |