Name: _____ Date: _____

DOB: ____/_____/_____ Account # _____

History and Intake Form

Preferred Language: _____Race:_____Ethnic Group:_____

(i.e. Caucasian, Asian, Hispanic) *(i.e. Chinese, Korean, Mexican, French)*

Medical History

- ☐ Anxiety
- ☐ Arthritis *Type*_____
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Autoimmune disorder
- ☐ Blood clots
- ☐ Cancer _____ *(types)*
- ☐ Depression
- ☐ Diabetes *Type 1 or 2*
- ☐ Heart attack/disease
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ High cholesterol
- ☐ Neuromuscular Disorder
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Lymphoma
- ☐ Seizures
- ☐ Stroke
- ☐ NONE

Other _____

Past Surgical History: *(Please list all surgeries)*

_____

Skin Disease History: *(Please circle all that apply)*

- ☐ Acne
- ☐ Actinic keratosis
- ☐ Basal cell CA
- ☐ Blistering sunburns
- ☐ Dry skin
- ☐ Eczema
- ☐ Flaking/Itchy scalp
- ☐ Hay fever/Allergies
- ☐ Hives
- ☐ Melanoma
- ☐ Cold Sores
- ☐ Poison ivy
- ☐ Precancerous moles
- ☐ Psoriasis
- ☐ Squamous cell CA
- ☐ 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)? _____

Medications/Vitamins:*(Please list all current prescriptions, and over-the-counter medications)*

Medication Name	Strength	Frequency		Medication Name	Strength	Frequency

Allergies: *(Please list all allergies)* **Describe Reactions**

_____

_____

Primary Care Physician's Name: _____ Phone (___)____-_____

Specialists for chronic conditions _____ **Phone (___)____-_____**

*Type: (cardiologist, rheumatologist, etc.)*_____

Specialists for chronic conditions _____ **Phone (___)____-_____**

*Type: (cardiologist, rheumatologist, etc.)*_____

Specialists for chronic conditions _____ **Phone (___)____-_____**

*Type: (cardiologist, rheumatologist, etc.)*_____

Pharmacy: _____ Phone (___)____-_____

Do you have a caregiver? If so, name _____

Medical History Intake Form

Patient Name:_____ Date of Birth:_____

Medical History ***Please Check all that apply:***

- ⬜Anxiety
- ⬜Arthritis
- ⬜Asthma
- ⬜Cerebrovascular accident (Stroke)
- ⬜Chronic Obstructive pulmonary Disease (COPD)
- ⬜ Coronary arteriosclerosis (Coronary disease)
- ⬜Depressive Disorder (Depression)
- ⬜Diabetes mellitus
- ⬜Disease Cause by Covid 19
- ⬜End-Stage Renal Disease
- ⬜Epilepsy
- ⬜Gastroesophageal reflux disease (GERD)
- ⬜Hypertension (High Blood Pressure)
- ⬜Hearing Loss
- ⬜Human immunodeficiency virus infection (HIV)
- ⬜Hypercholesterolemia (High Cholesterol)
- ⬜Hyperthyroidism (Overactive Thyroid)
- ⬜Hypothyroidism (Underactive Thyroid)
- ⬜Inflammatory disease of liver
- ⬜Leukemia
- ⬜Malignant Lymphoma
- ⬜Malignant Tumor of the Colon
- ⬜Radiation therapy treatment management
- ⬜Other:_____
- ⬜None

Past Surgery History ***Please Check all that apply:***

- ⬜Bilateral replacement of knee joints (Knee Replacement Left and Right)
- ⬜Excision of Basal Cell Carcinoma
- ⬜Excision of Melanoma
- ⬜Excision of Squamous Cell Carcinoma
- ⬜History of Colectomy(Colon surgery)
- ⬜Surgical biopsy of skin
- ⬜Total replacement of left hip joint
- ⬜Total replacement of left knee joint
- ⬜Total replacement of right hip joint
- ⬜Total replacement of right knee joint
- ⬜ Transplantation of heart (Heart transplant)
- ⬜ Transplantation of liver (Liver transplant)
- ⬜None

Skin Disease History ***Please Check all that apply:***

- ⬜Acne
- ⬜Actinic keratosis
- ⬜Asteatosis cutis
- ⬜Basal cell carcinoma of skin
- ⬜Dysplastic nevus of skin (Irregular Moles)
- ⬜Eczema
- ⬜None
- ⬜H/O: Asthma
- ⬜H/O: Hay fever
- ⬜Malignant melanoma
- ⬜Psoriasis
- ⬜Squamous cell carcinoma
- ⬜ Sunburn of second degree
- ⬜Other:_____

Do you wear sunscreen? ⬜YES ⬜NO If Yes, what strength SPF?_____

Do you tan in a tanning salon? ⬜YES ⬜NO

Do you have a family history of Melanoma? ⬜YES ⬜NO If Yes, which relative:_____

Medications ***Please List all Medicines you currently take:***

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies ***Please List all your Allergies to medications and any other allergies:***

_____	_____	_____	_____
_____	_____	_____	_____

Social History

Do you Smoke Cigarettes? ⬜YES ⬜NO Did you smoke cigarettes in the past? ⬜YES ⬜NO Do you drink Alcohol? ⬜YES ⬜NO

Do you regularly receive Flu vaccines: ⬜YES ⬜NO

For patients **65 and older**: Have you received a pneumonia vaccination? ⬜YES ⬜NO