NAME:____ **DATE OF BIRTH:**________________

History and Intake Form

Past Medical History: (please circle all that apply)

None
- Anxiety
- Arthritis
- Asthma
- Atrial fibrillation (Irregular Heartbeat)
- Bone Marrow Transplantation
- BPH (Benign Prostatic Hyperplasia)
- Breast Cancer
- Colon Cancer
- COPD (Emphysema)
- Coronary Artery Disease
- Depression
- Diabetes
- End Stage Renal Disease
- GERD (Acid reflux)
- Hearing Loss
- Hepatitis
- Hypertension
- HIV/AIDS
- Hypercholesterolemia
- Hyperthyroidism
- Hypothyroidism
- Leukemia
- Lung Cancer
- Lymphoma
- Prostate Cancer
- Radiation Treatment
- Seizures
- Stroke

Other ____

Past Surgical History: (please circle all that apply)

None
- Appendix (Appendectomy)
- Bladder (Cystectomy)
- Breast : Breast Biopsy
- Breast : Lumpectomy (Both, Left, Right)
- Breast : Mastectomy (Both, Left, Right)
- Colon (Colectomy) : Colon Cancer Resection
- Colon (Colectomy) : Diverticulitis
- Colon (Colectomy) : Inflammatory Bowel
- Colon: Colostomy
- Gallbladder (Cholecystectomy)
- Heart : Biological Valve Replacement
- Heart : Coronary Artery Bypass Surgery
- Heart : Heart Transplant
- Heart : Mechanical Valve Replacement
- Heart : PTCA
- Joint Replacement : Hip (Both, Left, Right)
- Joint Replacement : Knee (Both, Left, Right)
- Kidney : Kidney Biopsy
- Kidney : Kidney Stone Removal
- Kidney : Kidney Transplant
- Kidney : Nephrectomy
- Liver: Hepatectomy
- Liver: Liver Transplant
- Liver: Shunt
- Ovaries (Oophorectomy) : Endometriosis
- Ovaries (Oophorectomy) : Ovarian Cancer
- Ovaries (Oophorectomy) : Ovarian Cyst
- Ovaries: Tubal Ligation
- Pancreas: Pancreatectomy
- Prostate (Prostatectomy) : Prostate Biopsy
- Prostate (Prostatectomy) : Prostate Cancer
- Prostate (Prostatectomy) : TURP
- Rectum: APR
- Rectum: Low Anterior Resection
- Skin : Basal Cell Carcinoma
- Skin : Melanoma
- Skin : Skin Biopsy
- Skin : Squamous Cell Carcinoma
- Spleen (Splenectomy)
- Testicles (Orchiectomy)
- Uterus (Hysterectomy) : Fibroids
- Uterus (Hysterectomy) : Uterine Cancer
- Uterus (Hysterectomy): Cervical Cancer

Other ____

Skin Disease History: (please circle all that apply)

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

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)? ____

Any other family history: ____

Medications: (Please detail all medications including when, dose, how often)

____

____

____

____

Allergies: (Please enter all allergies **AND <u>REACTIONS</u>!)**

____

____

____

____

Pharmacy: Name:____

Street:______________________ City:______________ Zipcode:____________

Preferred Language: ____________________

Race: (circle one)
- American Indian/ Alaska Native
- Asian
- Black / African American
- Native Hawaiian / Pacific Islander
- White
- Other Race

Ethnicity: (circle one)
- Hispanic or Latino
- Not Hispanic or Latino
- Other:____________________

Social History: (Please circle all that apply)

Smoking Status

Current every day smoker
Current some day smoker (tobacco)
Current some day smoker (cigarette)
Former smoker
Never smoker
Smoker, current status unknown
Cigar Smoker

Start Smoking:____________________
Quit Smoking:____________________
Packs per day____________________
Years Smoking:____________________

Sexual History

Not sexually active
Sexually active with one partner
Sexually active with more than one partner
Same sex partner

Illicit Drug Use

Drug Use
IV drug use
No drug use

Alcohol Use

None
Less than 1 drink a day
1-2 Drinks a day
3 or more drinks a day

Safety

I feel safe at home
I do not feel safe at home

Driving Habits

Drives in Daytime
Drives at night

Exercise

Several times a day
Once a day
Few times a week
Few times a month
Never

Caffeine Use

Several Times a day
Once a day
Few times a week
Few times a month
Never

Occupation and Workplace______________________________
Birthplace (City & State):______________________________

Review of Systems: Are you currently experiencing any of the following?

Symptom	Yes	No
problems with bleeding		
Problems with healing		
Problems with scarring (hypertrophic or keloid)		
Rash		
Immunosuppression		
Hay fever		
Chest pain		
Fever or chills		
Night sweats		
Unintentional weight loss		
Thyroid problems		
Sore throat		
Blurry vision		
Abdominal pain		
Bloody stools		
Bloody urine		
Joint aches		
Muscle weakness		
Neck stiffness		
Headaches		
Seizures		
Cough		
Shortness of breath		
Wheezing		
Anxiety		
Depression		

Other: ____

Alerts:

Symptom	Yes	No
Transplant Recipient		
Allergy to adhesive		
Allergy to lidocaine		
Allergy to topical antibiotic ointment		
Artificial heart valve		
Artificial joints within past two years		
Blood thinners (not aspirin)		
Defibrillator		
MRSA		
Pacemaker		
Premedication prior to surgical procedures (NOT DENTAL)		
Rapid heartbeat with epinephrine		
Pregnancy or planning pregnancy		
Hepatitis C		
West Africa: Travel or Contact		
Ebola Risk		

Other: ____