Medical History Intake Form

Name: _____ D.O.B _____TODAY'S DATE: _____

Pharmacy: _____ Street Name/City:_____

Primary Care Doctor: _____Telephone No: _____

Reason for today's visit:_____

_____

Medications: (Please enter all current medication, *dosage not needed)

Allergies to Medications: (Please enter all allergies to medications)

Note: Please see reverse side

Past Medical History: (please circle all that apply)

Anxiety	Depression	Hypothyroidism (Underactive Thyroid)
Arthritis	Diabetes	Leukemia
Asthma	End Stage Renal Disease	Lung Cancer
Atrial fibrillation	GERD	Lymphoma
BPH (Benign Prostatic Hyperplasia)	Hearing Loss	Pacemaker
Bone Marrow Transplant	Hepatitis	Prostate Cancer
Breast Cancer	Hypertension (high blood pressure)	Radiation Treatment
Colon Cancer	HIV/AIDS	Seizures
COPD	High Cholesterol	Stroke
Coronary Artery Disease	Hyperthyroidism (overactive thyroid)	**NONE (circle if none applicable)**

Other:_____

Past Surgical History: (please circle all that apply)

Appendix Removed	PTCA	Prostate Removed: Prostate Cancer
Bladder Removed	Mechanical Valve Replacement	Prostate Biopsy
Mastectomy (Right, Left)	Biological Valve Replacement	TURP
Lumpectomy (Right, Left)	Heart Transplant	Skin Biopsy
Breast Biopsy (Right, Left)	Knee Replacement (Right, Left, Both)	Melanoma Surgery
Breast Implants or Reduction	Kidney Biopsy	Basal Cell Cancer Surgery
Colectomy: Colon Cancer Resection	Kidney Removed (Right, Left	Squamous Cell Surgery
Colectomy: Diverticulitis	Kidney Stone Removal	Spleen Removed
Colectomy: IBD	Kidney Transplant	Testicles Removed
Coronary Artery Bypass	Ovaries Removed: Endometriosis	Hysterectomy: Fibroids
Gallbladder Removed	Ovaries Removed: Cyst	Hysterectomy: Uterine Cancer
Ovaries Removed: Ovarian Cancer	Hip Replacement (Right, Left, Both)	**NONE (circle if none applicable)**

Other:_____

Skin Disease History: (Please circle all that apply)

Acne	Blistering Sunburns	Hay Fever/Allergies	Psoriasis
Actinic Keratoses	Dry Skin	Melanoma	Squamous Cell Skin
Asthma	Eczema	Precancerous Moles	Cancer
Basal Cell Skin Cancer	Flaking or Itchy Scalp	Poison Ivy	**NONE** (**circle if none applicable**)

Other:_____

PLEASE CIRCLE

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)?_____

Social History: (Please circle all that apply)

Currently Smokes – daily/not daily	Alcohol Consumption? Yes/No How often? _____
Has smoked in the past/ never smoked	Drug Use: Yes/No

Review of Systems: Are you currently experiencing any of the following? (Please circle all that apply)

Pacemaker	Artificial heart valve
Defibrillator	Artificial joints within past two years
Premedication prior to procedures	Taking blood thinners
Allergy to topical antibiotic ointments	Allergy to adhesive
Pregnancy, planning on a pregnancy, or nursing	Allergy to lidocaine
Rapid heartbeat epinephrine	GI upset with antibiotics
Fevers/ Sweats /Chills	**NONE (circle if none applicable)**