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 _____

Name: _____ Account # _____

Social History

Alcohol Use

☐None
☐Less than 1 drink per day
☐1-2 drinks per day
☐ 3 or more drinks per day

Tabacco Use

☐ Never smoked
☐ Former smoker
☐ Currently smokes

☐ How many times, in the past year, have you had more than 5 or more drinks for men or 4 or more drinks for women, in one day? ☐0 ☐1 ☐2 or more times

Family History *(Only first degree relatives-parents, full siblings, children) (i.e. allergies, diabetes, cancers, etc.)*

_____

_____

_____

Have you had a Pneumonia Vaccination? ☐Yes ☐No

Have you had your annual flu shot? ☐Yes ☐ No

Why? ☐ I Declined ☐Allergy to vaccine ☐ Flu shot not available

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

(Please check yes or no for the following)

Symptom	Yes	No	Symptom	Yes	No
Anxiety			Joint aches		
Bloody stool			MRSA/Staph Infection		
Bloody urine			Muscle weakness		
Blurry vision			Nausea		
Chest pain			Problems w/bleeding		
Cold sore			Problems w/healing		
Cough			Rapid heartbeat		
Depression			Rash		
Dizziness			Seizures		
Fever/chills			Shortness of breath		
Headaches			Wheezing		

Other_____

ALERTS: *(please check all that apply)*

☐Allergy to adhesive/tape/latex
☐Allergy to lidocaine
☐Allergy to topical antibiotics
☐Artificial heart valve
☐Artificial joint replacement
☐Blood thinners
☐Defibrillator
☐Fainter
☐MRSA
☐Pacemaker
☐Require antibiotics prior to a surgical procedure
☐Rapid heart beat with epinephrine
☐Stent
☐Are you pregnant or currently trying to get pregnant?