# HISTORY & INTAKE FORM

**Past Medical History**: (Check all that apply)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Atrial Fibrillation
- ☐ BPH
- ☐ Bone Marrow Transplantation
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Pacemaker
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Valve Replacement
- ☐ None
- ☐ Other _____

**Past Surgical History**: (Check all that apply)

- ☐ Appendix Removed
- ☐ Bladder Removed
- ☐ Mastectomy [Right, Left, Bilateral]
- ☐ Lumpectomy [Right, Left, Bilateral]
- ☐ Breast Biopsy [Right, Left, Bilateral]
- ☐ Breast Reduction
- ☐ Breast Implants
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Gallbladder Removed
- ☐ Coronary Artery Bypass
- ☐ PTCA
- ☐ Mechanical Valve Replacement
- ☐ Biological Valve Replacement
- ☐ Heart Transplant
- ☐ Joint Replacement,Knee [Right, Left, Bilateral]
- ☐ Joint Replacement,Hip [Right, Left, Bilateral]
- ☐ Joint Replacement within last 2 years
- ☐ Kidney Biopsy
- ☐ Kidney Removed [Right, Left]
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Ovaries Removed: Endometriosis
- ☐ Ovaries Removed: Cyst
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Prostate Removed: Prostate Cancer
- ☐ Prostate Biopsy
- ☐ TURP
- ☐ Skin Biopsy
- ☐ Basal Cell Cancer Surgery
- ☐ Squamous Cell Carcinoma Surgery
- ☐ Melanoma surgery
- ☐ Spleen Removed
- ☐ Testicles Removed [Right, Left, Bilateral]
- ☐ Hysterectomy: Fibroids
- ☐ Hysterectomy: Uterine Cancer
- ☐ None
- ☐ Other _____

**Skin Disease History: (check all that apply)**

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Asthma
- ☐ Basil Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ None
- ☐ Other

**Social History: (Please check all that apply)**

- ☐ Currently Smokes
- ☐ Has smoked in the past
- ☐ Drug Use
- ☐ 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)? _____ | | |

**Cautions: (please circle all that apply)**

| | | |
|---|---|---|
| Have you ever had difficulty stopping bleeding? | Yes | No |
| Do you require antibiotics prior to a surgical procedure? | Yes | No |
| Have you had an artificial joint replacement? | Yes | No |
| If yes, when and what body locations? _____ | Yes | No |
| Do you have an artificial heart valve? | Yes | No |
| Do you have a pacemaker? | Yes | No |
| Do you have a defibrillator? | Yes | No |
| Are you pregnant or currently trying to get pregnant? | Yes | No |

Medications: (Please enter all current medications)

_____

_____

_____

Allergies: (Please enter all allergies)

_____

_____

_____

**PLEASE SIGN**_____

**Review of Systems: Are you currently experiencing any of the following symptoms? (please check all that apply)**

- ☐ Abdominal Pain
- ☐ Anxiety
- ☐ Bleeding Problems
- ☐ Bloody Stool
- ☐ Bloody Urine
- ☐ Blurry Visiion
- ☐ Changing Mole
- ☐ Chest Pain
- ☐ Cough
- ☐ Depression
- ☐ Fever or Chills
- ☐ Headaches
- ☐ Hay Fever
- ☐ Joint Aches
- ☐ Muscle Weakness
- ☐ Neck Stiffness
- ☐ Night Sweats
- ☐ Rash
- ☐ Seizures
- ☐ Shortness of Breath
- ☐ Sore Throat
- ☐ Thyroid Problems
- ☐ Unintentional Weight Loss
- ☐ Wheezing
- ☐ Other Symptoms:

Ethnicity _____

Race _____

Language _____

Smoking Yes_____No____

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Official Use only

| **Date /Initials** | **Date /Initials** | **Date /Initials** | **Date /Initials** |
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**PLEASE SIGN:**_____

**DATE:**_____