

NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

**History and Intake Form**

**Past Medical History:** (please circle all that apply)

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

**Past Surgical History:** (please circle all that apply)

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

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

- |                        |                           |
|------------------------|---------------------------|
| Acne                   | Hay Fever/Allergies       |
| Actinic Keratoses      | Melanoma                  |
| Asthma                 | Poison Ivy                |
| Basal Cell Skin Cancer | Precancerous Moles        |
| Blistering Sunburns    | Psoriasis                 |
| Dry Skin               | Squamous Cell Skin Cancer |
| Eczema                 | None                      |
| Flaking or Itchy Scalp |                           |
| 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 enter all current medications)

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**Allergies:** (Please enter all allergies)

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**Social History:** (Please circle one)

Cigarette Smoking:

- Never smoked
- Quit: former smoker
- Smokes less than daily
- Smokes daily

Alcohol Use:

- YES
- NO

Language:

- English
- Spanish
- Other: \_\_\_\_\_

Race:

- White
- Black/African American
- Asian
- American Indian or Native Alaskan
- Native Hawaiian/Pacific Islander

Ethnicity:

- Hispanic/Latino
- Non-Hispanic/Latino

**Pharmacy:** Name: \_\_\_\_\_

Street: \_\_\_\_\_ Zipcode: \_\_\_\_\_

How often do you exercise?

- Once a day
- A few times a week
- A few times a month
- Never

What is your caffeine use?

- Once a day
- A few times a week
- A few times a month
- Never

Occupation and Workplace \_\_\_\_\_

Place of Residence \_\_\_\_\_