History and Intake Form

Patient Name: ______________________________ **Date of Birth:** ________________ **Date:** __________________

Primary Care Physician (name and location): ____

Reason for today's visit: ____ **Occupation** ________________

How did you hear about us? Physician Friend/ Family Website Reminder Letter Other ________________

Medical History: (circle all that apply)

Anxiety
Arthritis
Artificial joints
Asthma
Atrial Fibrillation
BPH
Bone Marrow Transplant
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis (A, B, C)
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Immunosuppressed
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Therapy
Seizures
Stroke
Valve Replacement
None
Other____

Surgical History: (circle all that apply)

Mastectomy (R, L, bilateral)
Lumpectomy (R, L, bilateral)
Breast reduction
Breast implant
Colectomy
Coronary Artery Bypass
Heart Valve Replacement
Heart Transplant
Knee replacement (R, L, bilateral)
Hip replacement (R, L, bilateral)
Joint replacement in past 2 years
Kidney removed (R, L)
Kidney Transplant
Ovaries removed (cyst, ovarian cancer)
Prostate removed: prostate cancer
Spleen removed
Testicles removed (R,L, bilateral)
Hysterectomy (fibroids, uterine cancer)
None
Other____

Skin Disease History: (circle all that apply)

Acne
Actinic Keratosis (pre-cancerous growths)
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Rosacea
Squamous Cell Skin Cancer
None
Other____

Do you have a **family** (blood relative) history of melanoma? Yes / No If yes, which relative(s)?______________

Do you have a **family** (blood relative) history of any other skin cancer (s) Yes / No If yes, which relative(s)?______________

Medications: (please list all current medications, including those used as needed, herbals and supplements)

____
____
____
____

Preferred Pharmacy: (Name, Street, City) ____

Drug or Contact Allergies: (please include your reaction) ______________________________________
____

Cigarette smoking:
Never Smoked
Quit: former smoker
Smokes less than daily
Smokes daily

Alcohol use:
Alcohol: none
Alcohol: less than 1 drink a day
Alcohol: 1 – 2 drinks a day
Alcohol: 3 or more drinks a day

TURN OVER; CONTINUED ON BACK

Review of Systems: Are you currently experiencing any of the following? (please check yes or no for the following)

Symptom	Yes	No
Problems with bleeding		
Problems with healing		
Problems with scarring (hypertrophic or keloid)		
Immunosuppression		
Chest Pain		
Shortness of breath		
Rash		
Changing mole		
Dry skin/ lips		
Nosebleeds		
Unintentional weight loss		
Change in appetite		
Headaches		
Ringing in the ears		
Blurry vision		
Abdominal pain		
Bloody stool		
Joint aches		
Anxiety		
Depression		
Thoughts of hurting yourself or others		
Fever/ chills		
Night sweats		
Sore throat		
Cough		
Muscle weakness		
Nausea or vomiting		
Irregular periods		
Seizures		
Dizziness		
Heat or cold intolerance		

Other Symptoms: ____

Alerts: Are any of the following true for current health? (please check yes or no for the following)

Alert	Yes	No
Pregnancy or planning a pregnancy		
Defibrillator		
Pacemaker		
Blood thinners		
Artificial heart valve		
Artificial joints in past two years		
Taken isotretinoin (Accutane) in the last year		
Immunosuppression		
HIV		
Hepatitis B or C		
History of Cancer		
History of melanoma		
Mole Map (professional full-body photography)		
Allergy to lidocaine		
Allergy to adhesive		
Allergy to topical antibiotic ointments		
Rapid heartbeat with epinephrine		
Yeast infections with antibiotics		
Premedication prior to procedures		
Gastrointestinal upset with antibiotics		