

Intake and History Form

Name: _____ Date: _____
Street Address: _____ City / State: _____
Zip Code: _____ Date of Birth: _____ Gender: _____
Phone Number (day): _____ Phone Number (day): _____
Email Address: _____
Emergency Contact: _____
Preferred Language: _____ Race: _____ Ethnic Group: _____

Preferred Pharmacy

Name: _____
Phone Number: _____
City or Zip Code: _____

Past Medical History

Select any of the following medical conditions you currently have:

- Anxiety
- Arthritis
- Asthma
- Atrial Fibrillation
- Bone Marrow Transplant
- BPH
- Breast Cancer
- Colon Cancer
- COPD
- Coronary Artery Disease
- Depression

- Diabetes
- End Stage Renal Disease
- GERD
- Hearing Loss
- Hepatitis
- Hypertension
- HIV / AIDS
- Hypercholesterolemia
- Hyperthyroidism
- Hypothyroidism
- Leukemia

- Lung Cancer
- Lymphoma
- Prostate Cancer
- Radiation Treatment
- Seizures
- Stroke
- NONE
- Other

Past Surgical History

Have you had any surgeries on the following organs?

- Appendix (Appendectomy)
- Bladder (Cystectomy)
- Breast: Breast Biopsy
- Breast: Lumpectomy (Right, Left, Bilateral)
- Breast: Mastectomy (Right, Left, Bilateral)
- Colon (Colectomy): Colon Cancer Resection
- Colon (Colectomy): Diverticulitis
- Colon (Colectomy): Inflammatory Bowel Disease
- Colon: Colostomy
- Gallbladder (Cholecystectomy)
- Heart: Coronary Artery Bypass Surgery
- Heart: Heart Transplant
- Heart: Mechanical Valve Replacement
- Heart: PTCA
- Joint Replacement: Hip (Right, Left, Bilateral)
- Joint Replacement: Knee (Right, Left, Bilateral)
- Kidney: Kidney Biopsy
- Kidney: Kidney Stone Removal
- Kidney: Kidney Transplant
- Kidney: Nephrectomy
- Liver: Hepatectomy
- Liver: Liver Transplant
- Live: Shunt

- Ovaries (Oophorectomy): Endometriosis
- Ovaries (Oophorectomy): Ovarian Cancer
- Ovaries (Oophorectomy): Ovarian Cyst
- Ovaries: Tubal Ligation
- Pancreas: Pancreatectomy
- Postate (Prostatectomy): Prostate Biopsy
- Prostate (Prostatectomy): Prostate Cancer
- Prostate (Prostatectomy): TURP
- Rectum: APR
- Rectum: Low Anterior Resection
- Skin: Basal Cell Carcinoma
- Skin: Melanoma
- Skin: Skin Biopsy
- Skin: Squamous Cell Carcinoma
- Spleen (Splenectomy)
- Testicles (Orchiectomy)
- Uterus (Hysterectomy): Fibroids
- Uterus (Hysterectomy): Uterine Cancer
- Uterus (Hysterectomy): Cervical Cancer
- NONE
- Other

Skin Disease History

Have you had any of the following?

- Acne
 - Actinic Keratoses
 - Asthma
 - Basal Cell Skin Cancer
 - Blistering Sunburns
 - Dry Skin
 - Eczema
 - Flaking or Itchy Scalp
 - Have Fever / Allergies
 - Melanoma
 - Poison Ivy
 - Precancerous Moles
 - Psoriasis
 - Squamous Cell Skin Cancer
 - 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?

- Mother
 - Father
 - Sister
 - Brother
 - Daughter
 - Son
 - Uncle
 - Aunt
 - Nephew
 - Niece
 - Grandmother
 - Grandfather
 - Grandson
 - Granddaughter
 - Other
-
-

Medications

List all current medications:

Allergies

List all allergies and reactions if known:

Social History

Smoking Status (please choose one):

- Current everyday smoker
- Current someday smoker
- Former smoker
- Never smoker
- Unknown if ever smoked

Start Smoking:

• mm/dd/yyyy _____

Quit Smoking:

• mm/dd/yyyy _____

Number of Packs Per Day: _____

Total Years Smoking: _____

Alcohol Intake (please choose one):

- None
- 1 or less per day
- 1-2 per day
- 3 or more per day

Driving Status:

- Drives in the Daytime
- Drives at Night

How often do you exercise?

- Unspecified
- Several times a day
- Once a day
- A few times a week
- A few times a month
- Never
- Other _____

What is your caffeine use?

- Unspecified
- Several times a day
- Once a day
- A few times a week
- A few times a month
- Never
- Other _____

Occupation and Workplace:

Place of Residence:

Family History

Please include only first-degree relatives:
