History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety
Asthma
Artificial Joints
Atrial Fibrillation
BPH (Benign Prostatic Hyperplasia)
Bone Marrow Transplant
Breast Cancer
Colon Cancer
COPD (Emphysema)
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism or Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
Other_____

Past Surgical History (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy: Right Left or Both
Lumpectomy: Right Left or Both
Breast Biopsy: Righ Left or Both
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Coronary Artery Bypass
PTCA
Mechanical Valve Replacement
Heart Transplant
Pacemaker
Knee Replacement Right Left or Both
Hip Replacement: Right Left or Both
Joint Replacement: Right Left or Both
Kidney Biopsy
Kidney Removed
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
Melanoma Surgery
Spleen Removed
Testicles Removed
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
Other_____

Primary Care Physician_____

Skin Disease History (please circle all that apply)

Acne	Hay Fever
Actinic Keratoses	Allergies
Basal Cell Skin Cancer	Melanoma
Blistering Sunburns	Poison Ivy
Dry Skin	Precancerous Moles
Eczema	Psoriasis
Flaking or itchy scalp	Squamous Cell Skin cancer

Other_____

Do you have sunscreen on today? Yes No SPF_____

Do you tan in a tanning salon? Yes No

Do you have a family history of melanoma? Yes No

If so, what relatives?_____

Allergies:

_____

_____

_____

Social History:

Cigarette Smoking	Alcohol Use
Never Smoked	None
Quit (former smoker)	Less than a drink a day
Smoke less than daily	1 a day
Smoke daily	One to two drinks a day
	1 a week or more
	1 a month
	1 a year

Occupation/Workplace:_____

Pharmacy name:_____

Pharmacy Address:_____

Please list the medications you are currently taking, the dosage, and the reason for the medication.

MEDICATION	DOSAGE	REASON
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		