

HISTORY AND INTAKE FORM

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| --- | --- | --- | --- |
| Patient Name | | Date of Birth | Sex |
| Race/Ethnicity | Primary Care Provider | Preferred Pharmacy | |
| Reason for today’s visit: | | | |
| How did you hear about us? | | | |



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| Past Surgical History | | | |
| Please circle those that apply | | | |
| Transplant If yes, year\_\_\_\_\_\_\_organ\_\_\_\_\_\_\_\_\_\_\_ | | Hysterectomy | |
| Pacemaker/Defibrillator | | Oophorectomy | |
| Artificial Joint If yes, year\_\_\_\_\_\_\_joint\_\_\_\_\_\_\_\_\_ | | C-section | |
| Heart Valve Replacement | | Mohs | |
| Plastic Surgery If yes, please describe: | | | |
| No Surgical History | | | |
| Skin History | | | |
| Please circle those that apply | | | |
| Acne | Eczema | | Squamous Cell Carcinoma |
| Actinic Keratosis/Pre-cancers | Dysplastic Moles | | Dry Skin |
| Basal Cell Carcinoma | Melanoma | | Blistering Sun Burn |
| Rosacea | Family History of Melanoma? Yes\_\_\_ No\_\_\_ Relative:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Psoriasis | Other? | | |
| Use of Sunscreen? \_\_\_Yes \_\_\_No | If you use sunscreen, what SPF? \_\_\_\_\_\_\_\_\_ | | |
| Tanning Bed Use? \_\_\_ Yes \_\_\_\_No |  | | |
| Current Medications | | | |
| Name of Medication | Dosage and Directions | | |
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**If you have allergies, please list and note reaction:**

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**Social History:**

Smoking: \_\_\_\_Current Smoker \_\_\_\_\_Former Smoker \_\_\_\_\_Never Smoker

Weekly Alcohol Intake: \_\_None \_\_Less than 1 drink a day \_\_1-2 drinks per day \_\_3 or more per day

How many times per year do you have 5 or more drinks in one day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Illicit Drug Use: \_\_Yes \_\_No If yes, what type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For patients 65 years or older**

Do you have a health care proxy in the event that you are unable to make medical decisions? \_\_Yes\_\_No

Do you have a living will? \_\_\_Yes \_\_\_No

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| --- | --- |
| Are you currently experiencing any of the following? (circle those that apply) | |
| New, non-healing or changing skin lesions | Bloody nose |
| Enlarged lymph nodes | Chest Pain |
| Fever/Chills | Pain in muscles/joints/bones |
| Night Sweats | Abdominal Pain |
| Unintentional Weight loss | Headaches |
| Difficulty Breathing/Shortness of Breath | Nausea |
| Cough | Vomiting |
| Rash | Diarrhea |
| Visual Changes | Depression |
| Suicidal Thoughts | Irritated/Dry/Itchy Eyes |
| Scarring Problems | Healing Difficulty |
| Bleeding Problems | Sore Throat |
| Bloody Urine/Stool | Wheezing |

|  |  |
| --- | --- |
| Health Alerts (circle those that apply) | |
| Pregnant/Planning Pregnancy | Blood Thinner |
| Rapid Heartbeat with Epinephrine | MRSA/Current Infection |
| Allergy to Lidocaine | Adhesive Allergy |

I have reviewed and completed the form. The information I have noted is true and accurate to the best of my knowledge.

**Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**