History and Intake Form

Name ____ **DOB** ____________________

Past Medical History: (please circle all that apply)

Anxiety	COPD (Emphysema)	Hypertension	Prostate Cancer
Arthritis	Coronary Artery Disease	HIV/AIDS	Radiation Treatment
Asthma	Depression	Hypercholesterolemia	Seizures
Atrial fibrillation	Diabetes	Hyperthyroidism	Stroke
BPH (Prostate Enlargement)	End Stage Renal Disease	Hypothyroidism	Valve Replacement
Bone Marrow Transplantation	GERD (Reflux)	Leukemia	None
Breast Cancer	Hearing Loss	Lung Cancer	
Colon Cancer	Hepatitis (Type A, B or C)	Lymphoma	

Other ____________________

Past Surgical History: (please circle)

Appendix Removed	PTCA (Angioplasty)	TURP
Bladder Removed	Joint Replacement __________	Skin Biopsy
Mastectomy (Right or Left)	Kidney Biopsy	Skin Cancer Surgery (BCC/SCC/Melanoma)
Lumpectomy (Right or Left)	Kidney Removed (Right,or Left)	Spleen Removed
Breast Biopsy	Kidney Stone Removal	Testicles Removed (Right, Left, Bilateral)
Breast Reduction	Organ Transplant __________	Hysterectomy (Fibroids/Cancer)
Breast Implants	Ovaries Removed: (Cancer/Cyst/Endometriosis)	Valve Replacement
Colectomy: (Cancer/IBD/Diverticuli)	Prostate Removed: Prostate Cancer	None
Gallbladder Removed	Prostate Biopsy	
Coronary Artery Bypass		

Other ________________________

Skin Disease History: (please circle all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratoses	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	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(s)? Please circle Mother Father Sister Brother Daughter Son
Do you have a family history of Diabetes? Yes No
If yes, which relative(s)? Please circle Mother Father Sister Brother Daughter Son

Medications: (Write NONE if none) (Please enter all current medications) (Use back if more space is needed or attach list)

____
____
____

Allergies to Medications (Please write NONE if none) (Please enter all allergies)

____
____

Social History: (Please circle all that apply)

- Currently smokes everyday
- Currently smokes – not daily
- Former smoker
- Never smoker

Name ____

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

Symptom	Yes	No
Skin Problems		
Significant Stress		
Depression		
Joint Aches		
Thyroid problems		
Irregular Menses		
Headaches		
Pacemaker		
Defibrillator		
Artificial Joints w/in last 2yrs		
Artificial Heart Valve		
Premedication prior to procedures		
Allergy to adhesive		
Allergy to topical antibiotic ointments		
Allergy to latex		
Blood Thinners		
Pregnancy or planning a pregnancy		
Allergy to Lidocaine		
Rapid Heart Beat with epinephrine		
Yeast infections with antibiotics		
GI upset with antibiotics		
Problems with bleeding		
Problems with healing		
Problems with scarring (hypertrophic or keloid)		
Immunosuppression		

Other Symptoms: ____