History & Intake Form

Demographic Information

Patient Name_____ Date of Birth____/____/_____
Race_____ Ethnicity **(Circle One)**: Hispanic/Latino Non-Hispanic/Latino

EMAIL _____ Weight_____ Primary Provider_____

Pharmacy Information
Pharmacy Name_____ Phone Number_____
Street/City_____ Zip-code _____

Review of Systems Are you ***currently*** experiencing any of the following: **(Circle all that apply)**

Problems with Bleeding
Problems with Healing
Problems with Scarring (Keloids)
Rash
Immunosuppression
Hay Fever
Chest Pain
Fever/Chills
Night Sweats
Unintentional Weight Loss
Sore Throat
Seizures
Cough
Shortness of Breath
Wheezing
Anxiety
Depression
Yeast Infection with Antibiotic Use
Blurry Vision
Abdominal Pain
Joint Aches
Muscle Weakness
Headaches
NONE

ALERTS (Circle all that apply)

Allergy to Adhesive
Allergy to Topical Antibiotics
Artificial Joint Replacement in the past 2 years
Defibrillator
Pacemaker
Rapid Heart Beat with Epinephrine
Allergy to Lidocaine
Artificial Heart Valve
Blood Thinners
MRSA
Require antibiotics prior to surgical procedures
NONE

Are you currently pregnant or trying to get pregnant? **YES** **NO**

Past Medical History (Circle all that apply)

Anxiety
Arthritis
Asthma
Atrial Fibrillation
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Hypothyroidism
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
High Blood Pressure
High Cholesterol
Hyperthyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
HIV/AIDS
NONE

Have you EVER received the pneumonia vaccine? **YES** **NO**

Did you get the flu vaccine this year? **YES** **NO**

Do you have a health care proxy in the event you are unable to make your own medical decisions? **YES** **NO**

Past Surgical History (Circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Kidney Biopsy
Kidney Removed (Left, Right)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Biopsy
Prostate Removed: Prostate Cancer
TURP (Prostate Removal)
Testicles Removed (Left, Right, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
Joint Replacement, Knee (Left, Right, Bilateral)
Joint Replacement, Hip (Left, Right, Bilateral)
NONE

Other_____

Skin Disease History (Circle all that apply)

Acne
Actinic Keratosis
Asthma
Basal Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking/Itching Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Skin Cancer
NONE

Do you wear Sunscreen? Yes No
Do you tan in a tanning salon? Yes No
Do you have a family history of **Melanoma**? Yes No If yes, please specify family member_____

Medications

_____

_____

Allergies

_____

_____

Social History

Smoking
Current Everyday Smoker
Current Someday Smoker
Never Smoker

Alcohol Use
Less than 1 drink per day
1-2 drinks per day
3 or more drinks per day
Alcohol none

Women - How many times in the past year have you had **4 or more** drinks in a day? _____
Men - How many times in the past year have you had **5 or more** drinks in a day? _____

Family Medical History (First degree relatives only)

Father_____
Mother_____
Brother(s)_____
Sister(s)_____

What is your occupation? _____