History and Intake Form

Name _____ **DOB**_____ **Today's Date**_____

Preferred Language_____

Race (Please Circle):
White
American Indian or Alaskan Native
Asian
Black or African American
Native Hawaiian or Other Pacific Islander
Other Race
Decline to Specify

Ethnic Group (Please Circle):
Decline to Specify
Hispanic or Latino
Non Hispanic or Latino
Unknown

What pharmacy do you use? (name and address or location description):

_____

Email Address:

_____

Preferred Phone Number for Appointment Reminders and Results:

_____

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Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone Marrow Transplantation
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: (please circle all that apply)

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

Other _____

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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 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)? _____

Do any of your first degree relatives (mother, father, sisters, brothers, children) have any significant medical problems? (Please list medical condition and in whom it occurs/occurred)

_____
_____
_____

Medications: (Please enter all current medications or provide a list)

_____
_____
_____

Medication Allergies: (Please enter all medication allergies or provide a list)

_____
_____

Social History: (please circle all that apply)

Cigarette Smoking:
- Never smoked
- Quit: former smoker
- Smokes less than daily
- Smokes daily

Illicit Drug Use:
- Drug Use
- IV Drug Use

Alcohol Use:
- None
- Less than 1 drink a day
- 1-2 drinks a day
- 3 or more drinks a day

Safety:
- I feel safe at home
- I do not feel safe at home

Other _____

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Are you experiencing any of the following: (please circle all that apply)

Malaise (A generalized feeling of being unwell)
A recent increased level of stress
Problems with bleeding
Problems with healing
Problems with scarring
Problems with your immune system (Immunosuppression)
Fever
Joint pain
None of the above

Do you have any of the following: (please circle all that apply):

Allergy to adhesive
Allergy to lidocaine
Allergy to topical antibiotics
Artificial heart valve
Artificial joint placed within the past two years
Blood thinners
Defibrillator
Pace maker
Need to pre-medicate prior to procedures
Rapid heartbeat with epinephrine
Pregnancy or planning a pregnancy
None of the above

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