History Intake Form

Patient Name:_____ **Date of Birth** _____
Race:_____ **Ethnic Group** _____ **Gender: M F**
Preferred Language_____
Email _____
Preferred Pharmacy_____
Pharmacy Phone_____
Pharmacy City or Zip _____
PCP _____

PLEASE CIRCLE ALL THAT PERTAIN TO YOU:

Anemia
Angina
Anxiety
Arthritis
Asthma
Atrial Fibrillation
Blood Transfusion
Bone Marrow Transplant
Breast Cancer
Colon Cancer
Congestive Heart Failure
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
Epilepsy
GERD
Hearing Loss
Heart Attack
Hepatitis
High/Low Blood Pressure
HIV/AIDS
High Cholesterol
Leukemia
Liver Disease
Lung Cancer
Lymphoma
Mitral Valve Prolapse
Prostate Cancer
Radiation Treatment
Seizures
Shortness of Breath
Stroke
Tuberculosis

NONE

SKIN DISEASE HISTORY: Circle all that pertain to you

Acne
Actinic Keratosis
Asthma
Basal Cell Cancer
Blistering Sunburn
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Precancerous Moles
Psoriasis
Squamous Cell Cancer
NONE

FAMILY HISTORY OF SKIN CANCER:_____
_____
_____
_____
_____

History Intake Form (page 2)

Name:_____

Do you wear sunscreen with Zinc? Yes No
If Yes, which one_____
Do you tan or have ever tanned in a tanning bed Yes No
Do you have a family history of Melanoma? Yes No
If yes, which relative(s)_____

PAST SURGICAL HISTORY: Please circle all that pertain to you

Appendix Removed
Bladder Removed
Breast Implants
Breast Reduction
Colectomy: Colon Resection
Colectomy: Diverticulitis
Colectiomy: IBD
Coronary Artery Bypass
Gallbladder Removed
Heart Transplant
Hysterectomy
Joint Replacement_____
Kidney Removal
Kidney Stone Removal
Kidney Transplant
Mastectomy
Lumpectomy
Ovarian Cancer
Ovaries Removed
Prostate Cancer
Spleen Removed
Testicles Removal

SOCIAL HISTORY: Please circle all that apply

Cigarette Smoking:
Current Smokes
Former Smoker
Never Smoked

Alcohol Use:
NONE
Less that 1 Drink A Day
1-2 Drinks Per Day
3 Or More Drinks Per Day

ALLERGIES TO MEDICATIONS:

_____
_____
_____

Please complete the following information about ALL medication include alternative medications and non-prescription medications.

Name: _____ Date of birth: _____

Medication name	***Dose***	***Frequency***	***Prescribing Practitioner***	***Reason for medication***