History and Intake Form

Past Medical History: (**please circle all that apply**).

Anxiety	Coronary Artery	Hypercholesterolemia
Arthritis	Disease	Hyperthyroidism
Artificial joints	Depression	Hypothyroidism
Asthma	Diabetes	Leukemia
Atrial fibrillation	End Stage Renal	Lung Cancer
BPH	Disease	Lymphoma
Bone Marrow	GERD	Pacemaker
Transplantation	Glaucoma	Prostate Cancer
Breast Cancer	Hearing Loss	Radiation Treatment
Cataracts	Hepatitis	Seizures
Colon Cancer	Hypertension	Stroke
COPD	HIV/AIDS	Valve Replacement

None of the Above Other _____

Past Surgical History: **(please circle all that apply)**

Appendix Removed	Kidney Biopsy
Bladder Removed	Kidney Removed (Right, Left)
Mastectomy (Right, Left, Bilateral)	Kidney Stone Removal
Lumpectomy (Right, Left, Bilateral)	Kidney Transplant
Breast Biopsy (Right, Left, Bilateral)	Ovaries Removed: Endometriosis
Breast Reduction	Ovaries Removed: Cyst
Breast Implants	Ovaries Removed: Ovarian Cancer
Colectomy: Colon Cancer Resection	Prostate Removed: Prostate Cancer
Colectomy: Diverticulitis	Prostate Biopsy
Colectomy: IBD	TURP
Gallbladder Removed	Skin Biopsy
Coronary Artery Bypass	Basal Cell Cancer Surgery
PTCA	Squamous Cell Carcinoma Surgery
Mechanical Valve Replacement	Melanoma Surgery
Biological Valve Replacement	Spleen Removed
Heart Transplant	Testicles Removed (Right, Left, Bilateral)
Joint Replacement, Knee (Right, Left, Bilateral)	Hysterectomy: Fibroids
Joint Replacement, Hip (Right, Left, Bilateral)	Hysterectomy: Uterine Cancer
Joint Replacement within last 2 years	
Pacemaker or Defibrillator	None of the Above

Other _____

Skin Disease History: **(please circle all that apply)**

Acne	Eczema	Psoriasis
Actinic Keratoses	Flaking or Itchy Scalp	Squamous Cell Skin
Asthma	Hay Fever/Allergies	Cancer
Basal Cell Skin Cancer	Melanoma	
Blistering Sunburns	Poison Ivy	
Dry Skin	Precancerous Moles	

None of the Above

Have you been on Accutane, Asorbica, or other isotretinoin? Yes/No

When did you take your last isotretinoin pill?

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)? _____

Medications: (Please enter all current medications)

_____
_____
_____

***Allergies**: (Please enter all allergies). Write "None" if you have no known drug allergies. ***

_____
_____

Social History: (Please circle all that apply)

Currently Smokes – daily, weekly?
_____Packs per day or per week
Has smoked in the past? Yes/No

Has never smoked
Drug Use

Occupation:
Alcohol Intake : Social Daily Weekly
Other_____

Review of Systems: Are you currently experiencing any of the following?
(Please **circle Yes or No** for the following)

Symptom	Yes	No
Itching	Yes	No
Burning	Yes	No
Shortness of Breath	Yes	No
Fever	Yes	No
Weight Loss	Yes	No
Night Sweats	Yes	No
Thyroid Disease	Yes	No
Seasonal Allergies	Yes	No
Asthma	Yes	No
Joint Pain	Yes	No
Are you Pregnant	Yes	No
First Day of Last Period	Yes	No
Trying to get Pregnant	Yes	No
Birth Control? What Type?		

Other Symptoms: _____