History and Intake Form

Name: _____ DOB: _____

Past Medical History:

Anxiety
Arthritis
Asthma
Atrial Fibrillation (Irregular Heartbeat)
Bone Marrow Transplantation
BPH (Benign Prostatic Hyperplasia)
Breast Cancer
Colon Cancer
COPD (Emphysema)
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD (Acid Reflux)
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Other: _____

Past Surgical History:

Appendix (Appendectomy)
Bladder (Cystectomy)
Breast: Breast Biopsy
Breast: Lumpectomy (Left, Right, Bilateral)
Breast: Mastectomy (Left, Right, Bilateral)
Breast Reduction
Breast Implants
Colon (Colectomy): Colon Cancer Resection
Colon (Colectomy): Diverticulitis
Colon (colectomy): Inflammatory Bowel Disease
Colon: Colostomy
Gallbladder (Cholecystetomy)
Heart: Biological Valve Replacement
Heart: Coronary Artery Bypass Surgery
Heart: Heart Transplant
Heart: Mechanical Valve Replacement
Heart: PTCA
Joint Replacement: Hip (Left, Right, Bilateral)
Joint Replacement: Knee (Left, Right, Bilateral)
Kidney: Kidney Biopsy
Kidney: Kidney Stone Removal
Kidney: Kidney Transplant (Left, Right)
Kidney: Nephrectomy (Removal) (Left, Right)
Liver: Hepatectomy (Removal)
Liver: Liver Transplant
Liver: Shunt
Ovaries (Oophorectomy): Endometriosis
Ovaries (Oophorectomy): Ovarian Cancer
Ovaries (Oophorectomy): Ovarian Cyst
Ovaries: Tubal Ligation
Pancreas: Pancreatectomy (Removal)
Prostate: Prostate Biopsy
Prostate: Prostatectomy (Removal)
Prostate: TURP
Rectum: APR
Rectum: Low Anterior Resection
Skin: Basal Cell Carcinoma
Skin: Melanoma
Skin: Skin Biopsy
Skin: Squamous Cell Carcinoma
Spleen: Splenectomy (Removal)
Testicles: Orchiectomy (Removal)
Uterus (Hysterectomy): Fibroids
Uterus (Hysterectomy): Uterine Cancer
Uterus (Hysterectomy): Cervical Cancer
Other: _____

Skin Disease History:

Acne
Actinic Keratosis
Asthma
Basal Cell Skin Cancer
Blistering/Sunburns
Dry Skin
Eczema
Flaky or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
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 list current along with dosage):

_____
_____
_____
_____

Allergies:

_____
_____
_____

Social History:

Smoking Status
Never smoker
Former smoker
Current smoker

Immunization
Influenza Yes / No
Pneumococcal Yes / No

Pharmacy:

Name: _____ Phone: _____

Address: _____