# HISTORY AND INTAKE FORM

**NAME:** _____ **DATE OF BIRTH:** _____

**Primary Doctor:** _____ **Referring Doctor:** _____

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

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH (Benign Prostatic Hyperplasia)
Bone Marrow Transplantation
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
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
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
PTCA
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
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
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
None

**PLEASE TURN OVER!!!**

Thank you

Other _____

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

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
None
Other _____

## *Do you have a family history of Melanoma?

Yes No

If yes, which relative(s)? _____
Any other family history: _____

**Medications**: (Please enter all current medications)

_____
_____
_____

**Allergies**: (Please enter all allergies)

_____

**Social History**: (Please circle one)

Cigarette Smoking:

Never smoked
Quit: former smoker
Smokes less than daily
Smokes daily

**Pharmacy:** Name: _____

Pharmacy Address: _____Zipcode: _____

Telephone Number: _____

**PATIENTS OVER THE AGE OF 65 COMPLETE BELOW**

**** Do you have an advanced care plan/will? Yes or No**

**** Do you have a surrogate? (a person to decide your medical issues if you cannot decide them for yourself) Yes or No**

**If yes, who? PERSON'S NAME: _____**

**Telephone#:_____**