Intake Form

Name: ______________________________________ Date: ______________

Date of Birth: ______________ Sex: □ Female □ Male

Referred By: ______________________________Primary Physician:_____________________________

Preferred Pharmacy (Name and Location): ____

SECTION I: HEALTH HISTORY

Past Medical History (as diagnosed by a physician):

Anxiety..☐ Yes ☐ No
Arthritis ....☐ Yes ☐ No
Asthma ....☐ Yes ☐ No
Atrial Fibrillation (Irregular Heartbeat) ....☐ Yes ☐ No
Benign Prostate Hypertrophy (BPH) ....☐ Yes ☐ No
Bone Marrow Transplant.............................☐ Yes ☐ No
Breast Cancer ....☐ Yes ☐ No
Colon Cancer ....☐ Yes ☐ No
COPD ....☐ Yes ☐ No
Coronary Artery Disease.............................☐ Yes ☐ No
Depression ....☐ Yes ☐ No
Diabetes ....☐ Yes ☐ No
End Stage Renal Disease ....☐ Yes ☐ No
GERD (Gastric Reflux).................................☐ Yes ☐ No
Hearing Loss ....☐ Yes ☐ No
Hepatitis B or C ....☐ Yes ☐ No
Hypertension (High Blood Pressure)..................☐ Yes ☐ No
HIV/AIDS ....☐ Yes ☐ No
Hypercholesterolemia (High Cholesterol) ....☐ Yes ☐ No
Hyperthyroidism ....☐ Yes ☐ No
Hypothyroidism...☐ Yes ☐ No
Leukemia ....☐ Yes ☐ No
Lung Cancer ....☐ Yes ☐ No
Lymphoma..☐ Yes ☐ No
Prostate Cancer ....☐ Yes ☐ No
Radiation Treatment...☐ Yes ☐ No
Seizures..☐ Yes ☐ No
Stroke ....☐ Yes ☐ No
Transplant of an organ ....☐ Yes ☐ No
*If yes, type*______________

List all other medical conditions: ____

Surgeries: Please list all surgeries you've had in the past 12 months: __________________________________
____
____
____

Past Skin Disease History:

Acne .... ☐ Yes ☐ No
Actinic Keratoses (Pre-Cancers)............... ☐ Yes ☐ No
Basal Cell Skin Cancer (BCC) .... ☐ Yes ☐ No
Blistering sunburns.................................. ☐ Yes ☐ No
Dry Skin... ☐ Yes ☐ No
Eczema .... ☐ Yes ☐ No
Flaking or Itchy Scalp............................... ☐ Yes ☐ No
Hay Fever/Allergies.................................. ☐ Yes ☐ No
Melanoma.. ☐ Yes ☐ No
Poison Ivy.. ☐ Yes ☐ No
Precancerous Moles .... ☐ Yes ☐ No
Psoriasis.. ☐ Yes ☐ No
Squamous Cell Skin Cancer (SCC) .... ☐ Yes ☐ No
Shingles... ☐ Yes ☐ No
Shingles Vaccine...................................... ☐ Yes ☐ No
If yes, year ____________

Family History of Non-Melanoma Skin Cancer
(Basal Cell Cancer, Squamous Cell Cancer)
____
____
____

Family History of Melanoma..................... ☐ Yes ☐ No
If yes, which relatives?
____
____
____
____

Other: ____________________________________

None .... ☐

Do you wear sunscreen? ☐ Yes ☐ No If yes, what SPF? _____ Do you tan in a tanning salon? ☐ Yes ☐ No

SCN

Continued on other side

List ALL **Medications** you are currently taking:

Name	Dosage	How Often

Are you **allergic** to any medications? □ YES □ NO If yes, please list:

Name	Reaction

Smoking Status:
- ☐ Never
- ☐ Current every day smoker
- ☐ Smoker current status unknown
- ☐ Former Smoker
- ☐ Current some day smoker

Do you drink alcohol? □ YES □ NO If YES_______ drinks per day.
Do you use IV Drugs? □ YES □ NO If YES, what? _______________

SECTION II: REVIEW OF SYSTEMS

Check below any that apply:

- ☐ Allergy to adhesives
- ☐ Allergy to latex
- ☐ Allergy to topical antibiotic ointments
- ☐ Artificial heart valve
- ☐ Defibrillator
- ☐ Pacemaker
- ☐ Blood thinners
- ☐ HIV
- ☐ Artificial joints
- ☐ Hepatitis C
- ☐ Problems with local anesthesia
- ☐ Immunosuppression
- ☐ Fever or chills
- ☐ Night sweats
- ☐ Unintentional weight loss or gain
- ☐ Sore throat
- ☐ Blurry vision
- ☐ Abdominal pain
- ☐ Bloody stool
- ☐ Bloody urine or kidney problems
- ☐ Anemia
- ☐ Blood clots
- ☐ Leg swelling
- ☐ Problems with bleeding
- ☐ Problems with healing
- ☐ Problems with scarring (hypertrophic or keloid)
- ☐ Joint aches
- ☐ Muscle weakness
- ☐ Headaches
- ☐ Pregnancy or planning a pregnancy
- ☐ Fainting
- ☐ HSV
- ☐ Cough
- ☐ Shortness of breath

Completed by **Patient** ____ (signature)

Entered by **MA/LPN/RN** _________________________ (initials)