



Intake and History Form

Patient Name: _____ Height: _____ Weight: _____

Date of Birth: _____ Age: _____ Gender: _____ Preferred Language: _____

Place of Birth (City, State and Zip): _____

Employer: _____ Occupation: _____

Primary Doctor: _____ Referring Doctor: _____

Preferred Pharmacy

Name: _____ Phone Number: _____ City: _____

What is the main concern for your visit today? _____

What areas of your body are affected? _____

How long have you had this concern? _____

Symptoms (circle all that apply): pain itch bleeding enlargement spreading burning redness
embarrassment blistering other: _____

What oral medications have you tried for this concern? _____

What topical medications (prescription or OTC) have you tried? _____

List any other treatments you have used: _____

Which of these products have been helpful? _____

Past Medical History

Select any of the following medical conditions that you currently have or have had:

- | | | |
|---|---|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> Colon Cancer |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Esophageal Reflux (GERD) | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Transplant of Bone Marrow |
| <input type="checkbox"/> Benign Prostatic Hyperplasia (BPH) | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cerebrovascular Accident (CVA) | <input type="checkbox"/> Hypercholesterolemia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Transplant (Organ): _____ |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis (Type): _____ | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Leukemia | _____ |
| <input type="checkbox"/> Disease caused by COVID-19 | <input type="checkbox"/> Lymphoma | _____ |
| <input type="checkbox"/> Elevated Blood Pressure | <input type="checkbox"/> Lung Cancer | _____ |
| | <input type="checkbox"/> Breast Cancer | _____ |

Past Surgical History

Select any of the following surgical procedures that you have had:

- | | |
|---|---|
| <input type="checkbox"/> Rectum: Abdominoperineal resection (APR) | <input type="checkbox"/> Breast: Lumpectomy (Right / Left / Both) |
| <input type="checkbox"/> Joint replacement: Knee (Right / Left / Both) | <input type="checkbox"/> Breast: Mastectomy (Right / Left / Both) |
| <input type="checkbox"/> Breast: Biopsy of Breast | <input type="checkbox"/> Heart: Mechanical Heart Valve Replacement |
| <input type="checkbox"/> Prostate: Biopsy of Prostate | <input type="checkbox"/> Ovaries (Oophorectomy) |
| <input type="checkbox"/> Heart: Coronary Artery Bypass Graft (CABG) | <input type="checkbox"/> Pancreas: Pancreatectomy |
| <input type="checkbox"/> Kidney: Kidney Transplant | <input type="checkbox"/> Kidney: Kidney Stone Removal |
| <input type="checkbox"/> Skin: Basal Cell Carcinoma | <input type="checkbox"/> Liver: Portosystemic Shunt Operation |
| <input type="checkbox"/> Skin: Malignant Melanoma | <input type="checkbox"/> Prostate: Prostatectomy |
| <input type="checkbox"/> Skin: Squamous Cell Carcinoma | <input type="checkbox"/> Joint Replacement: Hip (Right / Left / Both) |
| <input type="checkbox"/> Colon: Colostomy | <input type="checkbox"/> Spleen: Splenectomy |
| <input type="checkbox"/> Ovaries: Tubal ligation | <input type="checkbox"/> Skin: Skin Biopsy |
| <input type="checkbox"/> Appendix (Appendectomy) | <input type="checkbox"/> Kidney: Nephrectomy |
| <input type="checkbox"/> Gallbladder (Cholecystectomy) | <input type="checkbox"/> Testicle: Orchidectomy |
| <input type="checkbox"/> Colon (Colectomy) | <input type="checkbox"/> Heart Transplant |
| <input type="checkbox"/> Liver (Hepatectomy) | <input type="checkbox"/> Liver Transplant |
| <input type="checkbox"/> Heart: Percutaneous Transluminal Coronary Angioplasty (PTCA) | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Heart: Tissue Graft Heart Valve Replacement | _____ |
| <input type="checkbox"/> Bladder (Cystectomy) | _____ |
| <input type="checkbox"/> Prostate: Transurethral Prostatectomy (TURP) | _____ |
| <input type="checkbox"/> Hysterectomy | _____ |
| <input type="checkbox"/> Kidney Biopsy | _____ |
| <input type="checkbox"/> Rectum: Lower Anterior Resection | _____ |

Skin Disease History

Have you had any of the following:

- | | | |
|--|--|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Eczema | <input type="checkbox"/> Blistering Sunburns |
| <input type="checkbox"/> Actinic Keratosis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Dry Skin (Asteatosis Cutis) | <input type="checkbox"/> Hay Fever / Allergies | _____ |
| <input type="checkbox"/> Basal Cell Skin Cancer | <input type="checkbox"/> Malignant Melanoma | _____ |
| <input type="checkbox"/> Poison Ivy | <input type="checkbox"/> Flaking or Itchy Scalp | _____ |
| <input type="checkbox"/> Precancerous (Dysplastic) Moles | <input type="checkbox"/> Psoriasis | _____ |
| | <input type="checkbox"/> Squamous Cell Skin Cancer | _____ |

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 malignant melanoma? YES NO If yes, which relative? _____

Do you have a family history of Basal Cell Carcinoma (BCC) or Squamous Cell Carcinoma (SCC)? YES NO
If yes, which relative? _____

Patient Name: _____

Medications

List all current medications (prescription, OTC medications and supplements) including dose and frequency:

Medication Name	Dose	Frequency

Allergies

List all allergies to medications

Social History

Smoking Status (Choose one)

- Current everyday smoker
- Current occasional smoker
- Cigar smoker
- Former smoker
- Never smoker

Alcohol Intake (Choose one)

- None
- Less than 1 drink per day
- 1 to 2 drinks per day
- 3 or more drinks per day

How many times in the past year have you had 5 (for men) or 4 (for women) or more drinks in a day? _____

Immunizations

For patients 65 and older, have you received the Pneumococcal (Pneumovax) vaccine? YES NO

For patients 50 and older, have you received the Shingles (Zostavax) vaccine? YES NO

For all patients, have you received the Influenza vaccine this flu season? YES NO

Review of Systems

Are you currently or have you recently experienced any of the following (mark all that apply):

- | | | |
|--|--|--|
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Cough | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Pain/burning on urination |
| <input type="checkbox"/> Fever or chills | <input type="checkbox"/> Unintentional weight loss | <input type="checkbox"/> New onset of joint aches |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Numbness/weakness |

Alerts

Select any of the following that you have (mark all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Allergy to Adhesive | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Allergy to Lidocaine | <input type="checkbox"/> MRSA |
| <input type="checkbox"/> Allergy to Topical Antibiotic Ointment | <input type="checkbox"/> Premedication Prior to Procedures |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Rapid Heartbeat with Epinephrine |
| <input type="checkbox"/> Artificial Joint within the past 2 years | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> Planning Pregnancy |
| <input type="checkbox"/> Defibrillator | <input type="checkbox"/> Breastfeeding |

Patient or Patient Representative Signature

Date

Health Care Provider Signature

Date