HISTORY AND INTAKE FORM

| Patient Name | DOB | Can Leave Voicemail? □ Yes □ No | Phone |
|---|---|---|---|
| Primary Care Physician | Referring Physician | | Preferred Pharmacy (name and location) |
| Reason for Today Visit: | | | |

## Past Medical History (please check all that apply)

| | | |
|---|---|---|
| None | □ Depression | □ Immunosuppressive therapy |
| | □ Diabetes | □ Hepatitis |
| □ Anxiety | □ Hyperthyroidism | □ Leukemia |
| □ Arthritis | □ Hypothyroidism | □ Lymphoma |
| □ Asthma | □ Hay fever | □ Colon Cancer |
| □ Atrial fibrillation | □ Hypertension | □ Myocardial infarction (Heart Attack) |
| □ Autoimmune disease | □ Hearing loss | □ Radiation Therapy |
| □ Cerebrovascular accident (Stroke) | □ Heart disease | □ Seizure |
| □ Chemotherapy | □ HIV/AIDS | □ Gastroesophageal reflux disease |
| □ COPD | □ High cholesterol | □ Other |

## Past Surgical History (please check all that apply)

| | |
|---|---|
| □ None | □ Oophorectomy |
| □ Pacemaker/Defibrillator | □ Transplantation of kidney |
| □ Artificial Joint: _____Year:_____ | □ Transplantation of lung |
| □ Tubal ligation | □ Transplantation of heart |
| □ Heart valve replacement | □ Transplantation of liver |
| □ Hysterectomy | □ Other |

## Skin Disease History (please check all that apply)

| | | |
|---|---|---|
| □ None | □ Dysplastic/Atypical Moles | □ Squamous cell carcinoma |
| □ Acne | □ Eczema | □ Sunburn of second degree (Blistering) |
| □ Actinic keratosis | □ Melanoma | |
| □ Basal cell carcinoma | □ Psoriasis | |
| □ Dry skin | □ Rosacea | □ 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)?

## Current Medication ( May attach list of medications if preferred)

List any medications that you are currently taking. Include items as aspirin, vitamins, laxative, etc)

| Name of medication | Dose (strength and # per day) | Name of medication | Dose (strength and # per day) |
|---|---|---|---|
| 1. | | 5. | |
| 2. | | 6. | |
| 3. | | 7. | |
| 4. | | 8. | |

Do you give us permission to request prescription history information electronically from your pharmacy? □ Yes □ No

## Allergies/Sensitivities

| Name of medication | Reaction | Name of medication | Reaction |
|---|---|---|---|
| 1. | | 4. | |
| 2. | | 5. | |
| 3. | | 6. | |

## Social History

Smoking Status: □ Current every day smoker □ Current some day smoker □ Former smoker □ Never smoker

Weekly alcohol intake: □ None □ Casual drinker or less than 1 drink per day □ 1-2 drinks per day □ 3 or more drinks per day

How many times per year do you have 5+ drinks in one day? _____

Flu Vaccination: □ Administered this flu season □Administered previous flu season □ I do not/have not gotten the flu vaccine

(Continued on next page)

| Quality Measures (for patients 65 or older) | | | |
|---|---|---|---|
| Have you received a pneumonia vaccination? □ Yes □ No | | | |
| Do you have a health care proxy in the event that you are unable to make your own medical decisions? □ Yes □ No | | | |
| Do you have a living will? □ Yes □ No | | | |
| Which of the following statements reflects your wishes on advanced care recommendations?<br>□ Do not intubate. I do not wish to have a breathing tube, even if it is necessary to save my life.<br>□ Do not resuscitate. If my heart were to stop, I do not wish to have chest compressions or an AED to restart my heart.<br>□ Full Cardiopulmonary Resuscitation. I want full cardiopulmonary resuscitation effort to be made. | | | |
| **Review of systems: Are you CURRENTLY experiencing any of the following?** | | | |
| enlarged nodes, glands, or SQ nodules | □ Yes □ No | | |
| night sweats | □ Yes □ No | | |
| unintentional weight loss | □ Yes □ No | | |
| problems with bleeding | □ Yes □ No | | |
| problems with healing | □ Yes □ No | | |
| problems with scarring (hypertrophic or keloid) | □ Yes □ No | | |
| joint aches | □ Yes □ No | | |
| rash | □ Yes □ No | | |
| visual changes | □ Yes □ No | | |
| chest pain | □ Yes □ No | | |
| muscle weakness | □ Yes □ No | | |
| abdominal pain | □ Yes □ No | | |
| headaches | □ Yes □ No | | |
| artificial joints within past two years | □ Yes □ No | | |
| **Health Alerts (please list any that apply)** | | | |
| □ Pregnant or planning pregnancy | | □ Blood thinner | |
| □ Allergy to lidocaine | | □ MRSA | |
| □ Allergy to topical antibiotic ointments | | □ Allergy to adhesive | |
| □ Immunosuppression | | □ Pacemaker | |

I verify that the above information is true and accurate to the best of my knowledge.

Patient Signature:_____ Date:_____