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.	

(Continued on next page)

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
Td or Tetanus (19 or older) □ Administered □ I do not/have not gotten the vaccine
Tdap (19 or older) □ Administered □ I do not/have not gotten the vaccine
Zoster/Shingles (50 or older) □ Administered □ I do not/have not gotten the vaccine

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? □ Do not intubate. I do not wish to have a breathing tube, even if it is necessary to save my life. □ Do not resuscitate. If my heart were to stop, I do not wish to have chest compressions or an AED to restart my heart. □ 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:_____