![A logo on a black background

Description automatically generated]()

**PATIENT HISTORY AND INTAKE FORM**

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| **Patient Demographics** |
| Today’s Date: |
| Patient Name: |
| Patient Date of Birth: Patient Age: |

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| **Past Medical History (please circle all that apply):** | | | | | | |
| Arthritis | | End Stage Renal Disease (kidney disease) | | | Leukemia | |
| Asthma | | Hepatitis (A / B / C) | | | Lymphoma | |
| Atrial fibrillation | | High Blood pressure | | | Radiation Treatment | |
| Breast Cancer | | HIV/AIDS | | | Seizures | |
| Coronary Artery Disease (heart disease) | | High Cholesterol | | | Stroke | |
| Diabetes | | Hypothyroid or Hyperthyroid | | | NONE | |
| **Other (circle all that apply or list below):** | | | | | | |
| Autoimmune Disorders | Bleeding Disorders | | Cold Sores on Lips | Keloid Formation | | Scleroderma |

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| **Past Surgical History:** |
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| **Skin Disease History (please circle all that apply):** | | |
| Basal Cell Skin Cancer | Melanoma | Squamous Cell Skin Cancer |
| Blistering Sunburns | Precancerous Moles | Actinic Keratosis |
| NONE |  | |
| **Do you wear sunscreen?** Yes No | | |
| **Do you tan in a tanning salon?**  Yes No Previous | | |
| **Do you have a family history of skin cancer (basal cell, squamous cell, melanoma)?** Yes No | | |
| **If yes, which relative(s)?** | | |

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| **Medications (please enter all medications, including dose and frequency or attach list):** |
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| **Allergies (please enter all allergies):** |
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| **Height: Weight:** |

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| **Social History (please circle all that apply):** |
| Cigarette smoking: now previously never |
| Alcohol use: none # of drinks per day: |

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| **For patients 65 and older: Have you received a pneumonia vaccination?** Yes No |

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| **Family History of any Medical Conditions (only first-degree relatives; parents and siblings):** |
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| **Preferred Language:** |
| **Race:** |
| **Ethnic Group:** |
| *(Requirements of the Healthcare Reform Law)* |

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| **Pharmacy Information** |
| Preferred pharmacy: |
| Phone: |
| City or Zip Code: |

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| **Primary Care and Referring Provider(s)** |
| Primary Care Physician: |
| Referring Physician: |

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| **Review of Systems: Are you currently experiencing any of the following? (please check yes or no)** | | | | | |
| **Symptom** | **Yes** | **No** | **Symptom** | **Yes** | **No** |
| Weight loss |  |  | Shortness of breath |  |  |
| Depression |  |  | Chest pain |  |  |
| Muscle aches |  |  | Easy bruising |  |  |
| Joint pain |  |  | Blood clots |  |  |
| Fever |  |  | Swollen lymph nodes |  |  |

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| **Other symptoms:** |
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| **ALERTS (please circle all that apply):** | |
| Allergy to Adhesive or latex | MRSA |
| Allergy to local anesthetics | Pacemaker |
| Allergy to topical antibiotics | Require antibiotics prior to a dental or surgical procedure |
| Artificial heart valve | Rapid heartbeat with epinephrine |
| Artificial joint replacement | Are you pregnant or currently trying to get pregnant? |
| Blood thinners | Are you currently breastfeeding? |
| Defibrillator |  |