**History and Intake Form**

### Past Medical History: (please circle all that apply)

- Anxiety
- Depression
- Leukemia
- Arthritis
- Diabetes
- Lung Cancer
- Artificial joints
- End Stage Renal Disease
- Lymphoma
- Asthma
- GERD (Acid Reflux)
- Pacemaker
- Atrial fibrillation
- Hearing Loss
- Prostate Cancer
- BPH (Benign Prostatic Hyperplasia)
- Hepatitis
- Radiation Treatment
- Bone Marrow Transplantation
- Hypertension
- Seizures
- Breast Cancer
- HIV/AIDS
- Stroke
- Colon Cancer
- Hypercholesterolemia
- Valve Replacement
- COPD (Emphysema)
- Hyperthyroidism
- None
- Coronary Artery Disease
- Hypothyroidism
- Other_______________________________

### Past Surgical History: (please circle all that apply)

- Appendix Removed
- Mechanical Valve Replacement
- Ovaries Removed: Cyst
- Bladder Removed
- Biological Valve Replacement
- Ovaries Removed: Ovarian Cancer
- Mastectomy (Right, Left, Bilateral)
- Heart Transplant
- Prostate Removed: Prostate Cancer
- Lumpectomy (Right, Left, Bilateral)
- Joint Replacement, Knee (Right, Left, Bilateral)
- Prostate Biopsy
- Breast Biopsy (Right, Left Bilateral)
- Joint Replacement, Hip (Right, Left, Bilateral)
- TURP
- Breast Reduction
- Joint Replacement within last 2 years
- Skin Biopsy
- Breast Implants
- None
- Colectomy: Colon Cancer Resection
- Kidney Biopsy
- Squamous Cell Carcinoma Surgery
- Colectomy: Diverticulitis
- Kidney Removed
- Melanoma Surgery
- Colectomy: IBD
- Kidney Stone Removal
- Spleen Removed
- Gallbladder Removed
- Kidney Transplant
- Testicles Removed (Right, Left, Bilateral)
- Coronary Artery Bypass
- Ovaries Removed: Endometriosis
- Hysterectomy: Fibroids
- PTCA
- None
- Other_______________________________

### Skin Disease History: (please circle all that apply)

- Acne
- Dry Skin
- Poison Ivy
- Actinic Keratoses
- Eczema
- Precancerous Moles
- Asthma
- Flaking or Itchy Scalp
- Psoriasis
- Basal Cell Skin Cancer
- Hay Fever/Allergies
- Squamous Cell Skin Cancer
- Blistering Sunburns
- Melanoma
- None
- 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)?**

Any other family history: ____________________________________________________________

_______________________________________________________________
Medications: (Please enter all current medications)
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________

Allergies: (Please enter all allergies)
________________________________________________________________________________________________________

Allergic to Meds: which ones:
________________________________________________________________________________________________________

Social History: (Please circle one)

Cigarette Smoking:  
Never smoked  
Quit: former smoker  
Smokes less than daily  
Smokes daily

Alcohol Use:  
NO  
less than 1 drink per day  
1-2 drinks per day  
3 or more drinks per day

What is your caffeine use?  
Once daily  
A few times a week  
A few times a month  
Never

Race:  
White  
Black/ African American  
Asian  
American Indian or Native Alaskan  
Native Hawaiian/ Pacific Islander

Ethnicity:  
Hispanic/ Latino  
Non-Hispanic/ Latino

Language:  
English  
Spanish  
Other: ____________________________

How often do you exercise?  
Once a day  
A few times a week  
A few times a month  
Never

How often do you drive:  
__ Drives in the daytime  
__ Drives at night

Pharmacy:
Name: ____________________________________________________________
Main Intersection: ________________________________________________
Address: _________________________________________________________
Phone: __________________________________________________________

Where do you work: ______________________________________________
What is your position there? _______________________________________

Do you live alone? ____________