NAME:_____ **DATE OF BIRTH:**_____

History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation (Irregular Heartbeat)
Bone Marrow Transplantation
BPH (Benign Prostatic Hyperplasia)
Breast Cancer
Colon Cancer
COPD (Emphysema)
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD (Acid reflux)
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke

None

Other _____

Past Surgical History: (please circle all that apply)

Appendix (Appendectomy)
Bladder (Cystectomy)
Breast : Breast Biopsy
Breast : Lumpectomy (Both, Left, Right)
Breast : Mastectomy (Both, Left, Right)
Colon (Colectomy) : Colon Cancer Resection
Colon (Colectomy) : Diverticulitis
Colon (Colectomy) : Inflammatory Bowel
Colon: Colostomy
Gallbladder (Cholecystectomy)
Heart : Biological Valve Replacement
Heart : Coronary Artery Bypass Surgery
Heart : Heart Transplant
Heart : Mechanical Valve Replacement
Heart : PTCA
Joint Replacement : Hip (Both, Left, Right)
Joint Replacement : Knee (Both, Left, Right)
Kidney : Kidney Biopsy
Kidney : Kidney Stone Removal
Kidney : Kidney Transplant
Kidney : Nephrectomy
Liver: Hepatectomy
Liver: Liver Transplant
Liver: Shunt
Ovaries (Oophorectomy) : Endometriosis
Ovaries (Oophorectomy) : Ovarian Cancer
Ovaries (Oophorectomy) : Ovarian Cyst
Ovaries: Tubal Ligation
Pancreas: Pancreatectomy
Prostate (Prostatectomy) : Prostate Biopsy
Prostate (Prostatectomy) : Prostate Cancer
Prostate (Prostatectomy) : TURP
Rectum: APR
Rectum: Low Anterior Resection
Skin : Basal Cell Carcinoma
Skin : Melanoma
Skin : Skin Biopsy
Skin : Squamous Cell Carcinoma
Spleen (Splenectomy)
Testicles (Orchiectomy)
Uterus (Hysterectomy) : Fibroids
Uterus (Hysterectomy) : Uterine Cancer
Uterus (Hysterectomy): Cervical Cancer

None

Other _____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
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 of cancers: _____

Medications: (Please detail all medications including when, dose, how often)

_____
_____
_____
_____

Allergies: (Please enter all allergies **AND <u>REACTIONS</u>!)**

_____
_____
_____
_____

Pharmacy: Name:_____
Street:_____ City:_____ Zipcode:_____

Preferred Language: _____

Race: (circle one)
American Indian/ Alaska Native
Asian
Black / African American
Native Hawaiian / Pacific Islander
White
Other Race

Ethnicity: (circle one)
Hispanic or Latino
Not Hispanic or Latino
Other:_____

Birthplace (City & State):_____

Social History: (Please circle all that apply)

Smoking Status

Current every day smoker
Current some day smoker (tobacco)
Current some day smoker (cigarette)
Former smoker
Never smoker
Smoker, current status unknown
Cigar Smoker

Start Smoking:_____
Quit Smoking:_____
Packs per day_____
Years Smoking:_____

Sexual History

Not sexually active
Sexually active with one partner
Sexually active with more than one partner
LGBTQ

Illicit Drug Use

Drug Use
IV drug use
No drug use

Alcohol Use

None
Less than 1 drink a day
1-2 Drinks a day
3 or more drinks a day

Safety

I feel safe at home
I do not feel safe at home

Driving Habits

Drives in Daytime
Drives at night

Exercise

Several times a day
Once a day
Few times a week
Few times a month
Never

Caffeine Use

Several Times a day
Once a day
Few times a week
Few times a month
Never

Occupation and Workplace_____

Review of Systems: Are you currently experiencing any of the following?

Symptom	Yes	No
problems with bleeding		
Problems with healing		
Problems with scarring (hypertrophic or keloid)		
Rash		
Immunosuppression		
Hay fever		
Chest pain		
Fever or chills		
Night sweats		
Unintentional weight loss		
Thyroid problems		
Sore throat		
Blurry vision		
Abdominal pain		
Bloody stools		
Bloody urine		
Joint aches		
Muscle weakness		
Neck stiffness		
Headaches		
Seizures		
Cough		
Shortness of breath		
Wheezing		
Anxiety		
Depression		

Other: _____

Alerts:

Symptom	Yes	No
Transplant Recipient		
Allergy to adhesive		
Allergy to lidocaine		
Allergy to topical antibiotic ointment		
Artificial heart valve		
Artificial joints within past two years		
Blood thinners (not aspirin)		
Defibrillator		
MRSA		
Pacemaker		
Premedication prior to surgical procedures (NOT DENTAL)		
Rapid heartbeat with epinephrine		
Pregnancy or planning pregnancy		
Hepatitis C		
West Africa: Travel or Contact		
Ebola Risk		

Other: _____