Intake and History Form

Name: _____Date of Birth: _____ Date: _____

Past Medical History

Select any of the following medical conditions you currently have:

- ☐ None
- ☐ Anxiety disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Bipolar disorder
- ☐ Blood coagulation disorder
- ☐ Cerebrovascular accident
- ☐ Chronic obstructive lung disease
- ☐ Coronary arteriosclerosis
- ☐ Depressive disorder
- ☐ Diabetes mellitus
- ☐ Disease caused by 2019-nCoV
- ☐ Elevated blood pressure
- ☐ End-stage renal disease
- ☐ Epilepsy
- ☐ Gastroesophageal reflux disease
- ☐ Guillain-Barre syndrome
- ☐ H/O: Deep vein thrombosis
- ☐ H/O: asthma
- ☐ H/O: hay fever
- ☐ H/O: hypertension
- ☐ H/O: migraine
- ☐ H/O: thyroid disorder
- ☐ H/O: tuberculosis
- ☐ Hepatitis B virus
- ☐ Hepatitis C visus
- ☐ Human immunodeficiency virus infection
- ☐ Hypercholesterolemia
- ☐ Inflammatory bowel disease
- ☐ Inflammatory disease of liver
- ☐ Leukemia
- ☐ Malignant lymphoma
- ☐ Malignant tumor of breast
- ☐ Malignant tumor of lung
- ☐ Malignant tumor of prostate
- ☐ Multiple sclerosis
- ☐ Parkinson's disease
- ☐ Radiation therapy treatment management
- ☐ Other:

_____
_____
_____

Past Surgical History

Have you had any surgeries?

- ☐ None
- ☐ H/O: tubal ligation
- ☐ History of colectomy
- ☐ Hysterectomy
- ☐ Mechanical heart valve replacement
- ☐ Oophorectomy
- ☐ Splenectomy
- ☐ Total replacement of left hip joint
- ☐ Total replacement of left knee joint
- ☐ Total replacement of right hip joint
- ☐ Total replacement of right knee joint
- ☐ Transplantation of heart
- ☐ Transplantation of liver
- ☐ Other_____

_____

Intake and History Form

Skin Disease History

Have you had any of the following?

Skin Conditions

- ☐ None
- ☐ Acne
- ☐ Actinic keratosis
- ☐ Basal cell carcinoma of skin
- ☐ Dysplastic nevus of skin
- ☐ Eczema
- ☐ Malignant melanoma
- ☐ Psoriasis
- ☐ Squamous cell carcinoma
- ☐ Sunburn of second degree
- ☐ Other

_____

_____

Skin Protection

Do you wear Sunscreen?

◯ Yes ◯ No

If yes, what SPF? _____

Do you tan in a tanning salon?

◯ Yes ◯ No

Family History of Melanoma

Do you have a family history of Melanoma?

◯ Yes ◯ No

If yes, which relative?

- ☐ Mother
- ☐ Father
- ☐ Sister
- ☐ Brother
- ☐ Daughter
- ☐ Son
- ☐ Uncle
- ☐ Aunt
- ☐ Nephew
- ☐ Niece
- ☐ Grandmother
- ☐ Grandfather
- ☐ Grandson
- ☐ Granddaughter
- ☐ Other

_____

_____

Medications

List all current medications:

_____

_____

_____

_____

Allergies

List all allergies and reactions if known:

_____

_____

_____

_____

Intake and History Form

Social History

Smoking Status (please choose one):

- ☐ Current every day smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Unknown if ever smoked

Start Smoking:

- mm/dd/yyyy _____

Quit Smoking:

- mm/dd/yyyy _____

Number of Packs Per Day: _____

Total Years Smoking: _____

Alcohol Intake (please choose one):

- ☐ None
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day

What is your caffeine use?

- ☐ Unspecified
- ☐ Several times a day
- ☐ Once a day
- ☐ A few times a week
- ☐ A few times a month
- ☐ Never
- ☐ Other

_____

Occupation and Workplace:

_____

_____

Place of Residence:

_____

_____

Family History

Please include only first-degree relatives:

_____

_____

_____

Alerts

Add any alerts such as planning pregnancy

_____

_____

_____