DATE:_____

HISTORY AND INTAKE FORM

NAME:_____ _____ DOB:_____/_____/_____
(First) (Last)

PHARMACY:_____ LOCATION: _____ PHONE: (_____) _____

(Please circle all that apply)

PAST MEDICAL HISTORY

Anxiety	Depression	Leukemia
Arthritis	Diabetes	Lung Cancer
Asthma	End Stage Renal Disease	Lymphoma
Atrial Fibrillation	GERD	Prostate Cancer
Bone Marrow	Hearing Loss	Radiation Treatment
BPH	Hepatitis	Seizures
Breast Cancer	High Blood Pressure	Stroke
Colon Cancer	HIV/AIDS	OTHER:_____
COPD	High Cholesterol	_____
Coronary Artery Disease	Thyroid (Hyper/Hypo)	**NONE**

(Please circle all that apply)

PAST SURGICAL HISTORY:

Appendix Removed	Heart Transplant	Prostate Biopsy
Bladder Removed	PTCA	Prostate Removed/Prostate Cancer
Breast Biopsy(Right/ Left)	Joint Replacement	TURP (Prostate Removal)
Lumpectomy(Right/ Left)	Hip (Right/Left)	Skin Biopsy
Mastectomy (Right/Left)	Knee (Right/Left)	Excision of Basal Cell Carcinoma
Colectomy:	Kidney Biopsy (Nephrectomy)	Excision of Squamous Cell Carcinoma
Colon Cancer Resection	Kidney Removed (Right, Left)	Excision of Melanoma
Diverticulitis	Kidney Stone Removal	Spleen Removal
IBD	Kidney Transplant	Testicles Removed (Right/Left)
Gallbladder Removed	Liver Transplant	Hysterectomy: Fibroids
Coronary Artery Bypass	Ovaries Removed: Endometriosis	Hysterectomy: Uterine Cancer
Biological Valve Replacement	Ovaries Removed: Ovarian Cancer	OTHER:_____
Mechanical Valve Replacement	Ovaries Removed: Cyst	**NONE**

(Please circle all that apply)

SKIN DISEASE HISTORY

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	OTHER:_____

Do you have a **FAMILY** history of **Melanoma**? If yes, which relatives:_____

YES NO _____

MEDICATIONS: All current medications, vitamins, supplements **(Please provide separate attachment if more than 6 medications.)**		
Name Including Strength (mg)	**Dose/Frequency**	
	/	
	/	
	/	
	/	
	/	
	/	
ALLERGIES: ***LIST BELOW***	***_____NO KNOWN DRUG ALLERGIES***	

SOCIAL HISTORY: (Please check one) **Smoking Status:**

DAILY_____ OCCASIONAL_____ FORMER_____ NEVER_____

OTHER FAMILY HISTORY (ie cancer/diabetes/high blood pressure/thyroid/skin cancer/none):

REVIEW OF SYSTEMS:	Are you currently experiencing any of the following?	
	YES	**NO**
Problems with healing or scarring		
Joint Aches		
Fever or Chills		
Depression or Anxiety		
Headaches		
Cough		
Hay Fever or Asthma		
Dry Eyes		
Thyroid Problems		
Problems with Healing		
Changing Mole		
RASH		
Allergy to topical antibiotics		
Allergy to lidocaine		
Allergy to adhesive		
Aspirin or Blood Thinners		
Artificial Joint Replacement		
Pregnancy/Planning a pregnancy?		
Pacemaker or Defibrilator		
GI Upset with antibiotics		
Rapid heartbeat with epinephrine		
Premedicaton prior to procedures		
Artificial heart valve		
Other Symptoms:		