MEDICAL HISTORY AND INTAKE FORM

Patient Name: _____ Date: _____
Date of Birth: _____ Age: _____
Preferred Pharmacy: _____ Pharmacy Phone: _____
Pharmacy Address: _____
Primary Care Physician: _____Physician Phone: _____
Primary Physician Address: _____
Reason for Today's Visit: _____
_____

MEDICAL HISTORY (Please circle all that apply)

Anorexia
Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH (Benign Prostatic Hyperplasia
Bipolar Disorder
Bone Marrow Transplantation
Breast cancer
Colon Cancer
COPD (Emphysema)
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
Environmental Allergies
GERD (Acid Reflux)
Hearing Loss
Hepatitis
HIV/AIDS
Hypercholesterolemia
Hypertension
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lupus
Lymphoma
Obsessive Compulsive Disorder
Organ Transplantation
Pacemaker
Panic Disorder
Prostate Cancer
Radiation Treatment
Schizophrenia
Seizures
Stroke
Valve Replacement
None
Other _____

DERMATOLOGIC HISTORY (Please circle all that apply)

Accutane/Isotretinoin Use
Acne
Actinic Keratosis
Allergies
Alopecia
Bacterial Infection (Type: _____)
Basal Cell Carcinoma Skin Cancer
Blistering Sunburns
Contact Dermatitis
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever
Herpes (Type: _____)
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Carcinoma Skin Cancer
None
Other _____

PAST SURGICAL HISTORY (Please circle all that apply)

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

REVIEW OF SYSTEMS (Please circle all that apply)

Have you experienced or are you currently experiencing any of the following?

Changing mole	Yes	No		Headaches	Yes	No
Rash	Yes	No		Cough	Yes	No
Fever or chills	Yes	No		Shortness of breath	Yes	No
Problems with healing	Yes	No		Wheezing	Yes	No
Problems with scarring (hypertrophic or keloid)	Yes	No		Defibrillator	Yes	No
Immunosuppression	Yes	No		Blood thinners	Yes	No
Chest pain	Yes	No		GI upset with antibiotics	Yes	No
Night sweats	Yes	No		Allergy to adhesive	Yes	No
Unintentional weight loss	Yes	No		Allergy to lidocaine	Yes	No
Thyroid problems	Yes	No		Allergy to topical antibiotic ointments	Yes	No
Sore throat	Yes	No		Artificial heart valve	Yes	No
Blurry vision	Yes	No		Artificial joint within the past 2 years	Yes	No
Abdominal pain	Yes	No		MRSA	Yes	No
Hepatitis C	Yes	No		Premedication prior to procedures	Yes	No
Organ transplant	Yes	No		Rapid heartbeat with epinephrine	Yes	No
Joint aches	Yes	No		Neck Stiffness	Yes	No
Problems with bleeding	Yes	No		Pregnancy or planning a pregnancy	Yes	No
Muscle weakness	Yes	No		Nursing	Yes	No

FAMILY HISTORY (Please circle all that apply)

Mother: Living/Deceased Age: _____ Cause of Death: _____
Father: Living/Deceased Age: _____ Cause of Death: _____

Acne	Mother	Father	Sister	Brother	Daughter	Son	Other	None
Arthritis	Mother	Father	Sister	Brother	Daughter	Son	Other	None
Asthma	Mother	Father	Sister	Brother	Daughter	Son	Other	None
Diabetes	Mother	Father	Sister	Brother	Daughter	Son	Other	None
Eczema	Mother	Father	Sister	Brother	Daughter	Son	Other	None
Hay fever	Mother	Father	Sister	Brother	Daughter	Son	Other	None
Allergies	Mother	Father	Sister	Brother	Daughter	Son	Other	None
Lupus	Mother	Father	Sister	Brother	Daughter	Son	Other	None
Psoriasis	Mother	Father	Sister	Brother	Daughter	Son	Other	None
Basal Cell Carcinoma	Mother	Father	Sister	Brother	Daughter	Son	Other	None
Squamous Cell Carcinoma	Mother	Father	Sister	Brother	Daughter	Son	Other	None
Melanoma	Mother	Father	Sister	Brother	Daughter	Son	Other	None
Accutane/Isotretinoin Use	Mother	Father	Sister	Brother	Daughter	Son	Other	None
Cancer & Type (Other than Skin Cancer):	Mother	Father	Sister	Brother	Daughter	Son	Other	None

SUN EXPOSURE (Please check or circle all that apply)

When you are exposed to the sun do you:

- ☐ Always burn
- ☐ Usually burn, tan minimally
- ☐ Sometimes mild burn, tan uniformly
- ☐ Rarely burn, always tan well
- ☐ Very rarely burn, tan very easily
- ☐ Never burn, tan very easily

Where did you grow up? _____
Did you have sunburns every summer in childhood? Yes No
Have you had at least one blistering sunburn? Yes No If yes, how many? _____
Ever use a tanning bed? Yes No If yes, how many times/how often? _____
Do you wear sunscreen? Yes No If yes, what SPF? _____

SOCIAL HISTORY (Please circle all that apply)

Smoking:
Current smoker? Yes No If yes, how much? _____
Former smoker? Yes No If yes, how much? _____
Never smoker? Yes No

Alcohol Use:
Do you drink alcohol? Yes No Frequency: _____

Occupation: _____
Hobbies: _____
Any other information you would like us to know: _____
_____

Reviewed: _____ Date: _____Update: _____

Patient Name: _____ Encounter Date: _____/_____/_____
DOB: _____/_____/_____

Medication Record

It is important to our physicians that each of our patients update medications at each visit in order to prevent drug interactions, ensure patient safety and deliver quality care. We kindly ask all patients to list all medications. Always include over-the-counter, herbals and vitamins/mineral/dietary supplements. Please also list your drug allergies on the line below.

The clinical assistant will use the shaded area to review your medications with you for the next seven visits.

Drug Allergies: _____

				Shaded Area for Office Use Only						
			Appointment Date:							
Medications (Prescription, Over-the-Counters, Herbals, Vitamin/Mineral/Dietary Supplements)	Dose	Frequency (Ex. 2x/Day)	Route (Ex. Injection, By Mouth, Patch, etc.)	Is the patient currently taking these medications?						
				(Y/N)	(Y/N)	(Y/N)	(Y/N)	(Y/N)	(Y/N)	(Y/N)