



HISTORY AND INTAKE FORM

Today's Date: _____

Patient Full Name: _____
(Last) (First) (M.I.)

Date of Birth: _____

Reason for today's visit:

Past Medical History: (Circle all that apply)

Acne	Diabetes	Malignant Melanoma
Actinic Keratosis	Dysplastic Nevus	Merkel Cell Carcinoma
Anxiety	Eczema	Prostate Cancer
Arthritis	GERD	Psoriasis
Asthma	Hearing Loss	Radiation Treatment
Atrial Fibrillation	Hepatitis	Renal Disease
Basal Cell Carcinoma	High Blood Pressure	Seborrheic Dermatitis
Breast Cancer	High Cholesterol	Seizures
Colon Cancer	HIV/AIDS	Skin Cancer
COPD	Leukemia	Stroke
Coronary Artery Disease	Lung Cancer	Squamous Cell Carcinoma
Depression	Lymphoma	Thyroid Dysfunction

Other: _____

Past Surgical History: (Circle all that apply)

Appendectomy	Implantation of cardiac defibrillator	Operation of skin
Biopsy of skin	Joint Replacement	Organ Replacement
Cesarean Section	Mastectomy	Organ Transplant
Cholecystectomy	Oophorectomy	Thyroidectomy
Hysterectomy		TURP

Other: _____



Personal Skin History:

	Location(s) and Year(s)	Treatment(s)
Actinic Keratosis		
Basal Cell Carcinoma		
Dysplastic Moles		
Malignant Melanoma		
Squamous Cell Carcinoma		

Do you wear sunscreen? Yes No
 Do you have a history of blistering sunburns? Yes No
 Do you tan in a tanning salon? Yes No
 Do you have a family history of non-melanoma skin cancers? Yes No
 Do you have a family history of melanoma? Yes No

Medications: (Please enter all current medications and supplements.)

Drug Allergies:

Social History:

Are you a smoker? Yes No Never
 If so, amount per day: _____

Do you drink alcohol? Yes No Never
 If so, amount per day: _____

Do you ever use drugs? (Marijuana included) Yes No Never

Are you pregnant or breastfeeding? Yes No

Do you plan on becoming pregnant? Yes No
 If so, when: _____



Review of Systems: (Please check yes or no for the following.)

	Yes	No
Abdominal Pain		
Headaches		
Coughing		
Fever or Chills		
Shortness of Breath		
Anxiety or Depression		
Unexplained Weightloss		
Joint Pain		

Primary Care Physician: _____ **Preferred Pharmacy:** _____

Race/Ethnicity: _____ **Preferred Language:** _____