

Intake and History Form

Name: _____ Date of Birth: _____ Date: _____

Past Medical History

Select any of the following medical conditions you currently have:

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

Past Surgical History

Have you had any surgeries?

- | | |
|--|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Total replacement of left knee joint |
| <input type="checkbox"/> H/O: tubal ligation | <input type="checkbox"/> Total replacement of right hip joint |
| <input type="checkbox"/> History of colectomy | <input type="checkbox"/> Total replacement of right knee joint |
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Transplantation of heart |
| <input type="checkbox"/> Mechanical heart valve replacement | <input type="checkbox"/> Transplantation of liver |
| <input type="checkbox"/> Oophorectomy | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Splenectomy | _____ |
| <input type="checkbox"/> Total replacement of left hip joint | |

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
