History and Intake Form

Past Medical History: (please circle all that apply)
- Anxiety
- Arthritis
- Asthma
- Atrial fibrillation (Irregular Heartbeat)
- Bone Marrow Transplantation
- BPH (Benign Prostatic Hyperplasia)
- Breast Cancer
- Colon Cancer
- COPD (Emphysema)
- Coronary Artery Disease
- Depression
- Diabetes
- End Stage Renal Disease
- GERD (Acid reflux)
- Hearing Loss
- Hepatitis
- Hypertension
- HIV/AIDS
- Hypercholesterolemia
- Hyperthyroidism
- Hypothyroidism
- Leukemia
- Lung Cancer
- Lymphoma
- Prostate Cancer
- Radiation Treatment
- Seizures
- Stroke

Other

None

Past Surgical History: (please circle all that apply)
- Appendix (Appendectomy)
- Bladder (Cystectomy)
- Breast : Breast Biopsy
- Breast : Lumpectomy (Both, Left, Right)
- Breast : Mastectomy (Both, Left, Right)
- Colon (Colectomy) : Colon Cancer Resection
- Colon (Colectomy) : Diverticulitis
- Colon (Colectomy) : Inflammatory Bowel
- Colon: Colostomy
- Gallbladder (Cholecystectomy)
- Heart : Biological Valve Replacement
- Heart : Coronary Artery Bypass Surgery
- Heart : Heart Transplant
- Heart : Mechanical Valve Replacement
- Heart : PTCA
- Joint Replacement : Hip (Both, Left, Right)
- Joint Replacement : Knee (Both, Left, Right)
- Kidney : Kidney Biopsy
- Kidney : Kidney Stone Removal
- Kidney : Kidney Transplant
- Kidney : Nephrectomy
- Liver: Hepatectomy
- Liver: Liver Transplant
- Liver: Shunt
- Ovaries (Oophorectomy) : Endometriosis
- Ovaries (Oophorectomy) : Ovarian Cancer
- Ovaries (Oophorectomy) : Ovarian Cyst
- Ovaries: Tubal Ligation
- Pancreas: Pancreatectomy
- Prostate (Prostatectomy) : Prostate Biopsy
- Prostate (Prostatectomy) : Prostate Cancer
- Prostate (Prostatectomy) : TURP
- Rectum : APR
- Rectum: Low Anterior Resection
- Skin : Basal Cell Carcinoma
- Skin : Melanoma
- Skin : Skin Biopsy
- Skin : Squamous Cell Carcinoma
- Spleen (Splenectomy)
- Testicles (Orchiectomy)
- Uterus (Hysterectomy) : Fibroids
- Uterus (Hysterectomy) : Uterine Cancer
- Uterus (Hysterectomy): Cervical Cancer

None

Other
Skin Disease History: (please circle all that apply)

- Acne
- Actinic Keratoses
- Basal Cell Skin Cancer
- Blistering Sunburns
- Dry Skin
- Eczema
- Flaking or Itchy Scalp
- Melanoma

Other: 

Do you wear Sunscreen? Yes No
If yes, what SPF? 

Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? 

Any other family history of cancers: 

Medications: (Please detail all medications including when, dose, how often)

Allergies: (Please enter all allergies AND REACTIONS!)

Pharmacy: Name: 
Street: City: Zipcode: 

Preferred Language: 

Race: (circle one)
- American Indian/Alaska Native
- Asian
- Black/African American

Native Hawaiian/Pacific Islander
White
Other Race

Ethnicity: (circle one)
- Hispanic or Latino
- Not Hispanic or Latino
Other: 

Birthplace (City & State):
Social History: (Please circle all that apply)

Smoking Status
Current every day smoker
Current some day smoker (tobacco)
Current some day smoker (cigarette)
Former smoker
Never smoker
Smoker, current status unknown
Cigar Smoker

Start Smoking: __________________________
Quit Smoking: __________________________
# Packs per day __________________________
# Years Smoking: __________________________

Sexual History
Not sexually active
Sexually active with one partner
Sexually active with more than one partner
LGBTQ

Illicit Drug Use
Drug Use
IV drug use
No drug use

Alcohol Use
None
Less than 1 drink a day
1-2 Drinks a day
3 or more drinks a day

Safety
I feel safe at home
I do not feel safe at home

Driving Habits
Drives in Daytime
Drives at night

Exercise
Several times a day
Once a day
Few times a week
Few times a month
Never

Caffeine Use
Several Times a day
Once a day
Few times a week
Few times a month
Never

Occupation and Workplace ____________________________________________
**Review of Systems:** Are you currently experiencing any of the following?

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>problems with bleeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problems with healing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problems with scarring (hypertrophic or keloid)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rash</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immunosuppression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hay fever</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fever or chills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Night sweats</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unintentional weight loss</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thyroid problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sore throat</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blurry vision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdominal pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bloody stools</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bloody urine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Joint aches</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Muscle weakness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neck stiffness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headaches</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seizures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cough</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shortness of breath</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wheezing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Alerts:**

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transplant Recipient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy to adhesive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy to lidocaine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy to topical antibiotic ointment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Artificial heart valve</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Artificial joints within past two years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood thinners (not aspirin)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Defibrillator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MRSA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pacemaker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premedication prior to surgical procedures (NOT DENTAL)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rapid heartbeat with epinephrine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy or planning pregnancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis C</td>
<td></td>
<td></td>
</tr>
<tr>
<td>West Africa: Travel or Contact</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ebola Risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>