

History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety	Depression	Thyroid Problems
Arthritis	Diabetes	Hyper - Hypo
Asthma	End Stage Renal	Leukemia
Atrial fibrillation	Disease	Lung Cancer
Bone Marrow	GERD	Lymphoma
Transplantation	Hearing Loss	Prostate Cancer
Breast Cancer	Hepatitis	Radiation Treatment
Colon Cancer	High Blood pressure	Seizures
COPD	HIV/AIDS	Stroke
Coronary Artery	High Cholesterol	NONE
Disease		

Other _____

Skin Disease History: (please circle all that apply)

Acne	Flaking or Itchy Scalp	Squamous Cell Skin
Actinic Keratoses	Hay Fever/Allergies	Cancer
Basal Cell Skin Cancer	Melanoma	NONE
Blistering Sunburns	Poison Ivy	
Dry Skin	Precancerous Moles	
Eczema	Psoriasis	

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)? _____

Medications: (Please enter all current medications)

Drug Allergies: (Please enter all allergies)

Cigarette Smoking:

Currently Smokes
Has smoked in the past
Never smoked
Former Smoker

ALERTS: (please circle all that apply)

Blood thinners
Defibrillator
Pacemaker
Are you pregnant or currently trying to get pregnant?

Other _____

Family History of Skin Cancer, Eczema, Psoriasis or Acne (Only first degree relatives)

Preferred Language: _____

Race: _____

***Ethnic Group CIRCLE ONE (hispanic or non-hispanic) (Obama Care Mandated)**

Preferred pharmacy Name: _____

Phone#: _____

City or Zip code: _____

Referring Doctor: _____