

# 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

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### 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

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## Medications

List all current medications:

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## Allergies

List all allergies and reactions if known:

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# 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:

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### Place of Residence:

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## Family History

Please include only first-degree relatives:

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## Alerts

Add any alerts such as planning pregnancy

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