❑ Are you pregnant or currently trying to get pregnant? ❑Yes ❑No

Do you have an Advanced Care Plan (Advanced Directive)? ❑Yes Name of Surrogate:_____

❑No

Preferred Language: _____

Race:_____ Ethnic Group:_____

Only if you <u>DO NOT</u> wish to use our In-house dispensary, please note your pharmacy name down below:

Preferred pharmacy Name: _____

Phone#: _____ City or Zip code:_____

Review of Systems: Are you currently experiencing any of the following? If yes, please place a check mark in the boxes below. If none, please mark the "NONE" box.

Symptom:

❑Problems with bleeding	❑Blurry vison
❑Problems with healing	❑Abdominal pain
❑Problems with scarring (hypertrophic or keloid)	❑Bloody stool or urine
❑Rash	❑Joint aches
❑Immunosuppression	❑Muscle Weakness
❑Hay fever	❑Headaches
❑Chest pain	❑Seizures
❑Fever/ chills/ weight loss	❑Cough
❑Night sweats	❑Shortness of Breath
❑Neck stiffness	❑Wheezing
❑Thyroid Problems	❑Anxiety
❑Sore throat	❑Depression
❑ NONE, I have none of these symptoms	

Other current symptoms that are not listed above:

_____

_____

Patient Signature:_____ Date:_____

Medication Name	Strength (i.e. mg, gram)	Dose (i.e. 5,10, 500)	Frequency (i.e. daily, at night)	Form (i.e.tablet, capsule)	Route (i.e. oral, topical)

If you have a med-list, please give a copy of the list to the medical assistant so that we can add medications to the computer

Allergies: (Please enter all allergies, include reaction)

_____ Reaction _____
_____ Reaction _____
_____ Reaction _____

Social History:

Smoking Status:

- ☐Current every day smoker ⟶ When did you start smoking? _____
- ☐Current some day smoker (tobacco) ⟶ Number of packs a day? _____
- ☐Current some day smoker (cigarettes) ⟶ Total years smoking? _____
- ☐Former smoker
- ☐Never Smoker
- ☐Cigar Smoker

Alcohol Use (EtOH): None

- ☐ **NONE**
- ☐ Less than 1 drink per day
- ☐ 1-2 drinks per day
- ☐ 3 or more drinks per day

How many times in the past year have you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women or any adult older than 65?

☐ 0
☐ 1
☐ 2
☐ Greater than 2

Family History (Only IMMEDIATE relatives: Please list ANY OTHER Family History conditions (i.e. Cardiologic, Diabetes, any other type of Cancer, etc.)

_____

IMPORTANT ALERTS: (Please check off any of the below alerts for our practice to be aware of)

- ☐ Allergy to Adhesive
- ☐ Allergy to lidocaine
- ☐ Allergy to topical antibiotics
- ☐ Artificial heart valve
- ☐ Artificial joint replacement
- ☐ Blood thinners
- ☐ Defibrillator
- ☐ MRSA
- ☐ Pacemaker
- ☐ Require antibiotics prior to a surgical procedure
- ☐ Rapid heartbeat with epinephrine

Past Surgical History: (Please check all that apply)

- ☐ Appendix Removed
- ☐ Bladder Removed
- ☐ Breast
  - ☐ Breast Biopsy
  - ☐ Mastectomy (Right, Left, Bilateral)
  - ☐ Lumpectomy (Right, Left, Bilateral)
  - ☐ Breast Implants
- ☐ Colon
  - ☐ Colectomy: Colon Cancer Resection
  - ☐ Colectomy: Diverticulitis
  - ☐ Colectomy: Inflammatory Bowel disease (IBD)
- ☐ Gallbladder Removed
- ☐ Heart
  - ☐ Coronary Artery Bypass
  - ☐ Mechanical Valve Replacement
  - ☐ Biological Valve Replacement
  - ☐ Heart Transplant
  - ☐ PTCA
- ☐ Joint Replacement
  - ☐ Joint replacement within last 2 years
  - ☐ Hip (Right, Left Bilateral)
  - ☐ Knee (Right, Left, Bilateral)
- ☐ Kidney
  - ☐ Kidney Biopsy
  - ☐ Kidney Removed (Right, Left)
  - ☐ Kidney Stone Removal
  - ☐ Kidney Transplant
  - ☐ Tubal ligation
  - ☐ Kidney- Nephrectomy
- ☐ Liver
  - ☐ Hepatecomy
  - ☐ Liver Transplant
  - ☐ Shunt
- ☐ Ovaries
  - ☐ Ovaries Removed: Endometriosis
  - ☐ Ovaries Removed: Ovarian Cancer
  - ☐ Ovaries Removed: Cyst
- ☐ Pancreatectomy
- ☐ Prostate
  - ☐ Prostate Biopsy
  - ☐ Prostate Removed: Prostate Cancer
- ☐ Rectum Low Anterior Resection
- ☐ Skin
  - ☐ Basal Cell Carcinoma
  - ☐ Melanoma
  - ☐ Skin Biopsy
  - ☐ Squamous Cell Carcinoma
- ☐ Spleen Removed
- ☐ Testicles Removed (Right, Left, Bilateral)
- ☐ Uterus
  - ☐ Hysterectomy: Fibroids
  - ☐ Hysterectomy: Uterine Cancer
  - ☐ Cervical Cancer

☐ **NONE**

Other _____

Skin Disease History: (please circle all that apply)

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

Other _____

Do you wear Sunscreen? ☐ Yes, SPF _____ ☐ No

Do you tan in a tanning salon? ☐ Yes ☐ No

Do you have a family history of skin cancer? ☐ Yes

- ☐ Melanoma- If yes, Which relative? _____
- ☐ Other: ☐ Basal Cell ☐ Squamous Cell

Which Relative? _____

☐ No

Medications: MANDATORY SECTION (Please enter all current medications including: Strength, Dose, Form, Frequency, Route and Unit)

History and Intake Form

Today's Date: _____

Patient Name: _____ D.O.B _____ Age:_____

Mailing Address: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Primary on insurance: _____ Insured's D.O.B: _____

Referred by: _____
❑ M.D ❑ Self/Friend

Height: _____ (inches) Weight:_____(lbs.)

Main skin problem you want evaluated? _____

1. Body area:_____ Duration:_____
2. Previous treatment (all medicine used): ❑ None

_____

3. Changes: ❑None ❑ Color ❑ Size ❑ Elevation ❑ Hardness
4. Modifying factors: ❑ None ❑ History of Skin Exposure ❑ Other Immune Diseases ❑ Other Illness:_____
5. Symptoms: ❑ None ❑ Bleed ❑ Itch ❑ Pain ❑ Infection
6. Severity: ❑ None ❑ Occasional ❑ Constant

Complete list of all other skin areas, growths, skin symptoms, or questions you have:

_____

_____

Person who I agree to release medical information to: _____

In Case of Emergency: _____ Phone: _____ Cell: _____

May we leave personal medical information on your answering machine or cellphone? ❑ Yes ❑ No

Past Medical History: (Please check all that apply)

- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Atrial fibrillation (Irregular Heartbeat)
- ❑ Bone Marrow Transplantation
- ❑ Benign Prostatic Hyperplasia (BPH)
- ❑ Breast Cancer
- ❑ Colon Cancer
- ❑ COPD
- ❑ Coronary Artery Disease
- ❑ Depression
- ❑ Diabetes
- ❑ End Stage Renal Disease
- ❑ GERD
- ❑ Hearing Loss
- ❑ Hepatitis
- ❑ High Blood pressure
- ❑ HIV/AIDS
- ❑ High Cholesterol
- ❑ Hypothyroidism
- ❑ Hyperthyroidism
- ❑ Leukemia
- ❑ Lung Cancer
- ❑ Lymphoma
- ❑ Prostate Cancer
- ❑ Radiation Treatment
- ❑ Seizures
- ❑ Stroke
- ❑ **NONE**

Other _____