



History and Intake Form

Name: _____ DOB: _____ Age _____

Who is your Primary Care Provider: _____

Do you have a health care provider referral: Yes No

Who referred you: Self Other

Reason for visit today? _____

Can we leave a voicemail with Result details? Yes No

Phone Number: _____

Email: _____

Past Medical History: (please check all that apply)

None

- | | | |
|--|--|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hyper <input type="checkbox"/> Hypo |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> GERD | <input type="checkbox"/> Lung Cancer |
| <input type="checkbox"/> Bone Marrow Transplant | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> COPD | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stroke |

Other: _____

Past Surgical History (please check all that apply)

None

- | | |
|---|--|
| <input type="checkbox"/> Appendix Removed | <input type="checkbox"/> Joint replacement, Knee
(right, left, bilateral) |
| <input type="checkbox"/> Bladder Removed | <input type="checkbox"/> Joint replacement, Hip
(right, left, bilateral) |
| <input type="checkbox"/> Mastectomy (right, left, bilateral) | <input type="checkbox"/> Joint replacement within last 2 years |
| <input type="checkbox"/> Lumpectomy (right, left, bilateral) | <input type="checkbox"/> Kidney Biopsy (Nephrectomy) |
| <input type="checkbox"/> Breast Biopsy (right, left, bilateral) | <input type="checkbox"/> Kidney Removed (right, left) |
| <input type="checkbox"/> Breast Reduction | <input type="checkbox"/> Kidney Stone Removal |
| <input type="checkbox"/> Breast Implants | <input type="checkbox"/> Ovaries Remove Endometriosis |
| <input type="checkbox"/> Colectomy: Colon Cancer Resection | <input type="checkbox"/> Ovaries Removed Cyst |
| <input type="checkbox"/> Colectomy: Diverticulitis | <input type="checkbox"/> Ovaries Removed Ovarian Cancer |
| <input type="checkbox"/> Colectomy: IBD | <input type="checkbox"/> Prostate Removed Prostate Cancer |
| <input type="checkbox"/> Gallbladder Removed | <input type="checkbox"/> Prostate Biopsy |
| <input type="checkbox"/> Coronary Artery Bypass | <input type="checkbox"/> TURP (Prostate Removed) |
| <input type="checkbox"/> Mechanical Valve Replacement | <input type="checkbox"/> Spleen Removed |
| <input type="checkbox"/> Biological Valve Replacement | <input type="checkbox"/> Testicles Removed
(Right, Left, Bilateral) |
| <input type="checkbox"/> Heart Replacement | |
| <input type="checkbox"/> Hysterectomy Uterine | |
| <input type="checkbox"/> Hysterectomy Fibroids | |

OTHER _____

Skin Disease History (please check all that apply)

None

Acne

Actinic Keratosis

Asthma

Basal Cell Carcinoma

Blistering Sunburns

Dry Skin

Eczema

Flaking or Itchy Scalp

Hay Fever/Allergies

Melanoma

Poison Ivy

Precancerous Moles

Psoriasis

Squamous Cell Carcinoma

Rosacea

Other: _____

Family History of Non-Melanoma Skin Cancer

Family History of Melanoma

Do you use sunscreen? Yes No If yes, what SPF? _____

Do you tan in a tanning salon? Yes No

Medications and or Supplements: none

Drug Allergies: None

-

Social History: (please check all that apply)

Cigarette Smoking:

Currently Smokes, packs per day _____

Have Smoke in the Past

Never Smoked

Alcohol Use:

None

Less than 1 drink per day

1-2 drinks per day

3 or more drinks per day

Other Medical Family History (Only First-Degree Relatives):

Your Occupation: _____

Preferred Language: _____

Race: _____ . Ethnic Group: _____

What Pharmacy Do You Use: _____

Street/City/State?: _____

Please Check any of the following that apply

- | | |
|--|--|
| <input type="checkbox"/> Problems with bleeding | <input type="checkbox"/> Allergy to adhesive |
| <input type="checkbox"/> Problems with healing | <input type="checkbox"/> Allergy to lidocaine |
| <input type="checkbox"/> Problems with scarring | <input type="checkbox"/> Allergy to topical antibiotic ointments |
| <input type="checkbox"/> Rash | <input type="checkbox"/> Artificial joints within past two years |
| <input type="checkbox"/> Immunosuppression | <input type="checkbox"/> Blood Thinners |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Defibrillator |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> MRSA |
| <input type="checkbox"/> Fever or chills | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Premedication to procedures |
| <input type="checkbox"/> Unintentional Weight Loss | <input type="checkbox"/> Rapid heartbeat with epinephrine |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Pregnancy or planning a pregnancy |
| <input type="checkbox"/> Sore throat | <input type="checkbox"/> Prostate Removed Prostate Cancer |
| <input type="checkbox"/> Blurry vision | |
| <input type="checkbox"/> Abdominal pain | |
| <input type="checkbox"/> Bloody stool | |
| <input type="checkbox"/> Bloody urine | |
| <input type="checkbox"/> Joint aches | |
| <input type="checkbox"/> Muscle weakness | |
| <input type="checkbox"/> Neck stiffness | |
| <input type="checkbox"/> Headaches | |
| <input type="checkbox"/> Seizures | |
| <input type="checkbox"/> Cough | |
| <input type="checkbox"/> Shortness of breath | |
| <input type="checkbox"/> Wheezing | |
| <input type="checkbox"/> Anxiety | |
| <input type="checkbox"/> Depression | |

Other: _____

Are you interested in any cosmetic procedures?

- Dermapen
- Botox
- Fillers

Other: _____

If you are interested in any product or cosmetic promotions, please leave us your email address
