History and Intake Form Name: _____ Date of birth: _____

Pharmacy: _____ Primary Care Physician: _____

Past Medical History: (Circle all that apply)

Have you had the Pneumonia vaccination? YES NO Have you had the Influenza vaccination? YES NO

Arthritis	Coronary Artery Disease	HIV or Aids	Lymphoma
Asthma	Diabetes	High Cholesterol	Radiation Treatment
Atrial Fibrillation	End Stage Renal Disease	Hyperthyroid	Seizure disorder
Bone Marrow transplant	Hepatitis	Hypothyroid	Other:

Past Surgical History: (Circle all that apply)

Mechanical or Biological Valve Replacement	Joint Replacement in past 2 years. Which joint?	Spleen removed Other:

Skin Disease History: (Circle all that apply)

Acne	Blistering Sunburns	Hay fever/ Allergies	Psoriasis
Actinic Keratosis	Eczema	Melanoma	Squamous Cell Skin Cancer
Basal Cell Skin Cancer	Flakey or Itchy Scalp	Precancerous Moles	Other:

Do you wear Sunscreen? YES NO *If yes, what is the SPF? _____

Do you currently use a tanning Bed? YES NO *Have you used a tanning bed in the past? YES NO

Do you have a family history of Melanoma? YES NO *If yes, who? _____

Medications: (List or provide a list to copy)	**Allergies: (List all Allergies)**

Social History: (Circle all that Apply)

Cigarette Smoking? Current / Past / Never	Alcohol Use? None / Less than 1 a day / 1-2 a day / 3 or more a day

Preferred Language: _____ Race: _____ Ethnic Group: _____

Occupation: _____

Alerts: (Circle all that Apply)

Do you have Advanced Care Directive? _____ Who is your Proxy? _____

Allergy to adhesive tape	Artificial joint replacement	Defibrillator	Blood thinners
Allergy to Lidocaine	Artificial heart valve	MRSA	Pacemaker
Allergy to topical antibiotic	Require antibiotic prior to surgery	Rapid heart rate with Epinephrine	Pregnant or trying to get pregnant