History and Intake Form

NAME: _____ **DATE**:_____
Date of Birth: _____ Place of Birth: _____

Medical History: (please circle all that apply)

Anxiety	Depression	Hyperthyroidism
Arthritis	Diabetes	Hypothyroidism
Asthma	End Stage Renal Disease	Leukemia
Atrial fibrillation	GERD	Lung Cancer
Bone Marrow	Hearing Loss	Lymphoma
Breast Cancer	Hepatitis	Prostate Cancer
Colon Cancer	HIV/AIDS	Radiation Treatment
COPD	Hypercholesterolemia	Seizures
Coronary Artery Disease	Hypertension	Stroke
Transplantation	Vaginal Dryness	Stress Urinary Leakage

NONE Other_____
_____

Past Surgical History: (please circle all that apply)

Appendix Removed	Kidney Biopsy (Nephrectomy)
Bladder Removed	Kidney Removed (Right, Left)
Mastectomy (Right, Left, Bilateral)	Kidney Stone Removal
Lumpectomy (Right, Left, Bilateral)	Kidney Transplant
Breast Biopsy (Right, Left, Bilateral)	Ovaries Removed: Endometriosis
Breast Reduction	Ovaries Removed: Cyst
Breast Implants	Ovaries Removed: Ovarian Cancer
Colectomy: Colon Cancer Resection	Prostate Removed: Prostate Cancer
Colectomy: Diverticulitis	Prostate Biopsy TURP (Prostate Removal)
Colectomy: IBD	Skin biopsy
Gallbladder Removed	Spleen Removed
Coronary Artery Bypass	Testicles Removed (Right, Left, Bilateral)
Heart: Mechanical Valve Replacement	Hysterectomy: Uterine Cancer
Heart: Biological Valve Replacement	Hysterectomy: Fibroids
Heart Transplant	Joint Replacement within last 2 years

Joint Replacement: Hip (Right, Left, Bilateral)
Joint Replacement: Knee (Right, Left, Bilateral)
NONE Other_____

Skin Disease History: (please circle all that apply)

Acne	Eczema	Poison Ivy/Oak
Actinic Keratoses	Flaking or Itchy Scalp	Precancerous Moles
Basal Cell Carcinoma	Hay Fever/Allergies	Psoriasis
Blistering Sunburns	Melanoma	Squamous Cell Carcinoma
Dry Skin		Other:_____

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Do you wear sunscreen? Yes No If yes, what SPF? _____
Have you ever used a tanning salon? Yes ___ No ___ How often_____

Do you have a family history of Basal Cell Carcinoma or Squamous Cell Carcinoma or Melanoma? Yes No
If yes, which relative and what type? _____

Medications: (please enter all current prescriptions and over the counter medications, the dose, and # times taken daily)

_____
_____

Allergies: (please enter all allergies and type of reaction)

_____
_____

Social History: (please circle all that apply)

Smoking Status:	Alcohol Use:
Never Smoker	None
Former Smoker	Less than 1 drink per day
Current Day Smoker	1-2 drinks per day
Social Smoker	3 or more drinks per day

Preferred Language:_____ Race:_____ Ethnic Group: _____

PHARMACY preferred: Name and Cross Streets:
_____
City and Zip Code of Pharmacy: _____

ALERTS: (please circle all that apply)

Allergy to Adhesive	Allergy to lidocaine	Allergy to topical antibiotics
Allergy to Latex	Artificial heart valve	Artificial joint replacement
Blood thinners	Defibrillator	Pacemaker
Require antibiotics prior to a surgical procedure		MRSA
Rapid heartbeat with epinephrine		Pregnant/pregnancy planning/Nursing

SKIN CARE PRODUCTS and Aesthetician Services: I would like to learn more about skin care and the products you recommend Yes___ No___

COSMETIC: I would like to learn more about cosmetic procedures you offer [circle below]

BOTOX, Restylane and Juviderm FILLERS, LASERS: Excel V and IPL for red or brown spots, or veins, Fraxel and Accupulse for aging, wrinkling, or scarring, COOLSCULPT for body contouring, KYBELLA for double chin, Microneedling and PRP , EYELID LIFT, Fem Touch VAGINAL REJUVENATION to reverse vaginal dryness or stress urinary leakage , etc.