Updated Intake and History Form

Date of visit: _______________________

Name: ____ **Date of birth:** ______________________

Preferred Pharmacy

Name: ____ **City or Zip Code:** ____

Medications

List all current medications or provide a copy of your medications list:

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____
____
____

Allergies

List all allergies and reactions if known:

____
____
____

Medical or Surgical History

List all new medical or surgical history since your last visit:

____
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____

Skin Disease History

List all new medical or surgical history since your last visit:

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Review of Systems

Do you have any of the following?

◯ New onset of shortness of breath
◯ Recent illness
◯ Problems with scarring
◯ Rash

Required Insurance Questionnaire

YES NO
◯ ◯ Would you like to have life saving measures performed in an emergency?
◯ ◯ Do you have a surrogate decision maker for your medical decisions?
If yes; please list name of decision maker and contact number;
NAME: _______________________________ CONTACT NUMBER:__________________________
◯ ◯ Have you had your pneumonia vaccination?
◯ ◯ Do you have a history of Melanoma?
◯ ◯ Do you smoke cigarettes?
◯0 ◯1 ◯2+ MEN: How many times in the past year have you had 5 or more drinks in a day?
◯0 ◯1 ◯2+ WOMEN & ADULTS 65+: How many times in the past year have you had 4 or more drinks in a day?