Yearly Intake and History Form

Name: _____ Date of birth: _____

Date of visit: _____ Street Address: _____

City / State: _____ Zip Code: _____ Phone Number: _____

Preferred Pharmacy: _____ City or Zip Code: _____

Please list who we have permission to share medical information with:

_____

Allergies

List all allergies and reactions if known:

_____

_____

Past Medical History

Select any of the following medical conditions and medications you take for the diagnosis you currently have:

CONDITION:	MEDICATION:	CONDITION:	MEDICATION:
◯ Anxiety	_____	◯ Hearing Loss	_____
◯ Arthritis	_____	◯ Hepatitis	_____
◯ Asthma	_____	◯ High Blood Pressure	_____
◯ Atrial Fibrillation	_____	◯ HIV / AIDS	_____
◯ Bone Marrow Transplant	_____	◯ High Cholesterol	_____
◯ Enlarged Prostate (BPH)	_____	◯ Hyperthyroidism	_____
◯ Breast Cancer	_____	◯ Hypothyroidism	_____
◯ Colon Cancer	_____	◯ Leukemia	_____
◯ COPD	_____	◯ Lung Cancer	_____
◯ Heart Bypass (CAD)	_____	◯ Lymphoma	_____
◯ Stent Placement (CAD)	_____	◯ Prostate Cancer	_____
◯ Depression	_____	◯ Radiation Treatment	_____
◯ Diabetes	_____	◯ Seizures	_____
◯ End Stage Renal Disease	_____	◯ Stroke	_____
◯ GERD	_____	◯ NONE	

Other medical history and medications:

_____

_____

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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 _____
◯ ◯ Have you had your flu shot this year?
◯ ◯ Have you had your pneumonia vaccination?
◯ ◯ Do you have a history of Melanoma?
◯ ◯ Do you have psoriasis that is being treated by a biologic?
◯ ◯ Do you smoke cigarettes?
◯ ◯ Do you drink alcohol?
◯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?

Past Surgical History

Have you had any surgeries on the following organs?

◯ Joint Replacement (Right or Left)(Hip or Knee) Year? _____
◯ Mastectomy (Right or Left)
◯ Heart Valve Replacement
◯ Pacemaker
◯ Heart stent placement
◯ Heart Bypass

Other pertinent surgeries:

_____
_____

Skin Disease History

Have you had any of the following?

◯ 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

Do you wear Sunscreen? YES NO
If yes, what SPF? _____
Do you tan in a tanning salon? YES NO

Do you have a family history of Melanoma? YES NO
If yes, which relative? _____

Social History

Smoking Status:

◯ Never smoker
◯ Former smoker
◯ Current every day smoker
◯ Current some day smoker

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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

Alerts

Do you have any of the following?

- ◯ Problems with healing
- ◯ Problems with bleeding
- ◯ Allergy to latex
- ◯ Allergy to adhesive
- ◯ Allergy to lidocaine
- ◯ Allergy to topical antibiotic ointments
- ◯ Artificial heart valve
- ◯ Artificial joints within past two years
- ◯ Blood thinners
- ◯ Defibrillator
- ◯ MRSA
- ◯ Pacemaker
- ◯ Premedication prior to procedures
- ◯ Rapid heartbeat with epinephrine
- ◯ HIV
- ◯ Hepatitis B or C
- ◯ Planning a pregnancy
- ◯ Currently pregnant