Name:_____

Medical History and Intake Form

What is the reason for your visit today?

_____

Past Medical History: (please check all that apply)

Anxiety	Coronary Artery Disease	HIV/AIDS	Stroke
Arthritis	Depression	Hyperthyroidism	None
Asthma	Diabetes	Hypothyroidism	
Atrial Fibrillation	Kidney Disease	Leukemia	
Enlarged Prostate	Esophageal Reflux	Lung Cancer	
Bone Marrow Transplant	Hearing Loss	Lymphoma	
Breast Cancer	Hepatitis	Prostate Cancer	
Colon Cancer	High Blood Pressure	Radiation Treatment	
COPD	High Cholesterol	Seizures	

Other_____

Past Surgical History: Please list surgeries you have had within the last 10 years

_____

Skin Disease History: (please circle all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratosis	Eczema	Precancerous Moles
Asthma	Flaking/Itchy Scalp	Psoriasis
Basal Cell Cancer	Hay Fever/Allergies	Squamous Cell Cancer
Blistering Sunburns	Melanoma Cancer	None

Do you have a family history of Melanoma (please circle) Yes No
If yes, which relative(s)? _____

Medications: Please list all current medications:

_____
_____
_____

Medication Allergies: Please list all allergies to medications:

_____
_____

Social History: (please circle)

Smoke:	Yes	No
Alcohol:	Yes	No
Drug Use:	Yes	No

Are you currently experiencing or do you have any of the following? (Please circle all that apply)

Problems with scarring (keloids)
Immuno-suppression
Changing Mole
Rash
Abdominal Pain
Anxiety
Bloody Stool
Blurry Vision
Chest Pain
Cough
Depression
Fever or Chills
Headaches
Hay Fever
Joint Aches
Muscle Weakness
Neck Stiffness
Night Sweats
Shortness of Breath
Sore Throat
Sores that won't heal
Skin lesions that are new or changing
Bleeding lesions

Thyroid problems
Unintentional Weight Loss
Wheezing
Personal History of Melanoma
Pacemaker
Defibrillator
Artificial Joints
Artificial Heart Valve
Premedication prior to procedure
Allergic to Adhesives
Allergy to Antibiotic Ointment
Blood Thinner
Pregnancy/Planning Pregnancy
Breast Feeding
Allergy to Lidocaine
Rapid Heartbeat w/epinephrine
Yeast Infection with Antibiotics
GI Upset with Antibiotics
Problems with Bleeding
Seizures

Other symptoms: _____

Preferred pharmacy: _____

Primary Care Physician Name: _____

Primary Care Physician Phone#_____

Referred by: _____