Name: _____

Medical History and Intake Form

What is the reason for your visit today?

_____

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_____

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

_____

Personal 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:

OVER

Social History: (please circle)

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

Are you pregnant or planning pregnancy Yes No

Are you breastfeeding Yes No

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

Allergy to Lidocaine
Allergy to Antibiotic Ointment
Allergy to Adhesive
Pacemaker
Defibrillator
Blood Thinner
Artificial Heart Valve
Artificial Joints
New Skin Lesions
Changing Mole
Sores that won't heal
Rash
Immunosuppression
Muscle Weakness
Fever or Chills
Headaches
Blurry Vision
Dizziness
Anxiety
Depression
Abdominal Pain
Flu Symptoms/ Nausea
Bloody Stool
Joint Aches
Chest Pain
Cough
Neck Stiffness
Night Sweats
Shortness of breath
Sore Throat

Preferred pharmacy:

_____