

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**History and Intake Form**

**What is the reason for your visit today?**

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**Past Medical History:** (please circle all that apply)

Anxiety	Coronary Artery	Hyperthyroidism
Arthritis	Disease	Hypothyroidism
Artificial joints	Depression	Leukemia
Asthma	Diabetes	Lung Cancer
Atrial fibrillation	End Stage Renal	Lymphoma
BPH	Disease	Pacemaker
Bone Marrow	GERD	Prostate Cancer
Transplantation	Hearing Loss	Radiation Treatment
Breast Cancer	Hepatitis	Seizures
Colon Cancer	Hypertension	Stroke
COPD	HIV/AIDS	Valve Replacement
	Hypercholesterolemia	None

Other \_\_\_\_\_

**Past Surgical History:** Please list all surgeries that you have had:

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**Skin Disease History:** (please circle all that apply)

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

Other \_\_\_\_\_

Do you tan in a tanning salon?    Yes    No

Do you have a family history of Melanoma?    Yes    No

If yes, which relative(s)? \_\_\_\_\_

**Medications:** (Please enter all current medications and circle any that are new)

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