Name: ___________________________________Preferred Pharmacy____________________________________

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
Allergy to Lidocaine	Yes	No
Allergy to Antibiotic Ointments	Yes	No
Allergy to Adhesive	Yes	No
Pacemaker	Yes	No
Defibrillator	Yes	No
Blood Thinners	Yes	No
Artificial Heart Valve	Yes	No
Artificial Joints	Yes	No
Avoid Blood draw/inject/blood pressure In specific arm	Yes	No

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

New Skin Lesions	Depression
Changing Mole	Abdominal Pain
Sores that won't heal	Flu Symptoms/Nausea
Rash	Bloody Stool
Immunosuppression	Joint Aches
Muscle Weakness	Chest Pain
Fever or Chills	Cough
Headaches	Neck Stiffness
Blurry Vision	Night Sweats
Dizziness	Shortness of Breath
Anxiety	Sore Throat