Intake and History Form

Name: _____ Date: _____

Street Address: _____ City / State: _____

Zipe Code: _____ Date of Birth: _____ Gender: _____

Phone Number (day): _____ Phone Number (day): _____

Email Address: _____

Emergency Contact: _____

Preferred Language: _____ Race: _____ Ethnic Group:_____

Preferred Pharmacy

Name: _____

Phone Number: _____

City or Zip Code: _____

Past Medical History

Select any of the following medical conditions you currently have:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ NONE
- ☐ Other

_____

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_____

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Past Surgical History

Have you had any surgeries on the following organs?

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast: Breast Biopsy
- ☐ Breast: Lumpectomy (Right, Left, Bilateral)
- ☐ Breast: Mastectomy (Right, Left, Bilateral)
- ☐ Colon (Colectomy): Colon Cancer Resection
- ☐ Colon (Colectomy): Diverticulitis
- ☐ Colon (Colectomy): Inflammatory Bowel Disease
- ☐ Colon: Colostomy
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart: Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Joint Replacement: Hip (Right, Left, Bilateral)
- ☐ Joint Replacement: Knee (Right, Left, Bilateral)
- ☐ Kidney: Kidney Biopsy
- ☐ Kidney: Kidney Stone Removal
- ☐ Kidney: Kidney Transplant
- ☐ Kidney: Nephrectomy
- ☐ Liver: Hepatectomy
- ☐ Liver: Liver Transplant
- ☐ Live: Shunt
- ☐ Ovaries (Oophorectomy): Endometriosis
- ☐ Ovaries (Oophorectomy): Ovarian Cancer
- ☐ Ovaries (Oophorectomy): Ovarian Cyst
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Postate (Prostatectomy): Prostate Biopsy
- ☐ Prostate (Prostatectomy: Prostate Cancer
- ☐ Prostate (Prostatectomy): TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Spleen (Splenectomy)
- ☐ Testicles (Orchiectomy)
- ☐ Uterus (Hysterectomy): Fibroids
- ☐ Uterus (Hysterectomy): Uterine Cancer
- ☐ Uterus (Hysterectomy): Cervical Cancer
- ☐ NONE
- ☐ Other

_____

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Intake and History Form

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
- [ ] Have Fever / Allergies
- [ ] Melanoma
- [ ] Poison Ivy
- [ ] Precancerous Moles
- [ ] Psoriasis
- [ ] Squamous Cell Skin Cancer
- [ ] NONE
- [ ] Other

_____

_____

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?

- [ ] Mother
- [ ] Father
- [ ] Sister
- [ ] Brother
- [ ] Daughter
- [ ] Son
- [ ] Uncle
- [ ] Aunt
- [ ] Nephew
- [ ] Niece
- [ ] Grandmother
- [ ] Grandfather
- [ ] Grandson
- [ ] Granddaughter
- [ ] Other

_____

_____

Intake and History Form

Medications

List all current medications:

_____
_____
_____

Allergies

List all allergies and reactions if known:

_____
_____
_____

Social History

Smoking Status (please choose one):

- ☐ Current everyday smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Unknown if ever smoked

Start Smoking:

- mm/dd/yyyy _____

Quit Smoking:

- mm/dd/yyyy _____

Number of Packs Per Day: _____

Total Years Smoking: _____

Alcohol Intake (please choose one):

- ☐ None
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day

Driving Status:

- ☐ Drives in the Daytime
- ☐ Drives at Night

How often do you exercise?

- ☐ Unspecified
- ☐ Several times a day
- ☐ Once a day
- ☐ A few times a week
- ☐ A few times a month
- ☐ Never
- ☐ Other _____

What is your caffeine use?

- ☐ Unspecified
- ☐ Several times a day
- ☐ Once a day
- ☐ A few times a week
- ☐ A few times a month
- ☐ Never
- ☐ Other _____

REVIEWED (check all that apply)	SYSTEM	PREVIOUSLY REVIEWED	
❑ Problems with bleeding	Hematologic/Lymphatic	Y	N
❑ Problems with healing	Integumentary	Y	N
❑ Problems with scarring (hypertrophic or Keloid)	Integumentary	Y	N
❑ Rash	Integumentary	Y	N
❑ Immunosuppression	Allergic/Immunologic	Y	N
❑ Hay Fever	Allergic/Immunologic	Y	N
❑ Chest Pain	Cardiovascular	Y	N
❑ Fever or Chills	Constitutional/Symptom	Y	N
❑ Night Sweats	Constitutional/Symptom	Y	N
❑ Unintentional weight loss	Constitutional/Symptom	Y	N
❑ Thyroid Problems	Endocrine	Y	N
❑ Sore Throat	ENT and Mouth	Y	N
❑ Blurry Vision	Eyes	Y	N
❑ Abdominal Pain	Gastrointestinal (GI)	Y	N
❑ Bloody Stool	Gastrointestinal (GI)	Y	N
❑ Bloody Urine	Genitourinary (GU)	Y	N
❑ Joint Aches	Musculoskeletal	Y	N
❑ Muscle Weakness	Musculoskeletal	Y	N
❑ Neck Stiffness	Musculoskeletal	Y	N
❑ Headaches	Neurological	Y	N
❑ Seizures	Neurological	Y	N
❑ Cough	Respiratory	Y	N
❑ Shortness of Breath	Respiratory	Y	N
❑ Wheezing	Respiratory	Y	N
❑ Anxiety	Psychiatric	Y	N
❑ Depression	Psychiatric	Y	N
❑ Allergy to Adhesives	_____		
❑ 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	_____		
❑ Pregnancy or planning pregnancy	_____		
❑ West Africa: Travel or Contact	_____		
❑ Ebola Risk: Fever >= 100.4 Degrees (F)/38(C)	_____		

❑ Ebola Risk: Resided or Traveled to Country with wide-spread Ebola transmission in the last 21 days: Yes_____No_____

ADVANCED CARE-

Name: _____ DOB:_____Date: _____

Do you have a Living Will?

- ☐ **Yes**
- ☐ **No**

Which Statement(s) best reflects your wishes on Advanced Care recommendations?

- ☐ **DO NOT INTUBATE: I do not wish to have a breathing tube, even if it is necessary to save my life.**

- ☐ **DO NOT RESUSCITATE: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it is necessary to save my life.**

- ☐ **FULL CARDIOPULMONARY RESUSCITATION: I want full cardiopulmonary resuscitation efforts to be made.**

Signature:_____Date:_____