Review of Systems: Are you currently experiencing any of the following?
(Please check yes or no for the following)

Symptom	Yes	No
Problems with bleeding		
Problems with healing		
Problems with scarring		
Problems with keloids		
Rash		
Immunosuppression		
Hay Fever		
Fever or chills		
Night sweats		
Unintentional weight loss		
Thyroid problems		
Sore Throat		
Heartburn		
Hives		
Joint Aches		

Other Symptoms:

_____

ALERTS: (please circle all that apply)

Allergy to Adhesive
Allergy to lidocaine
Allergy to topical antibiotics
Artificial heart valve
Artificial joint replacement
Blood thinners
Defibrillator
MRSA
Pacemaker
Require antibiotics prior to a surgical procedure
Rapid heart beat with epinephrine
Are you pregnant or currently trying to get pregnant? Yes or No

History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial Fibrillation
Enlarged Prostate
Stroke
COPD
Heart Disease
Depression
Diabetes
High Blood pressure
End Stage Renal Disease
Epilepsy
GERD
Hearing Loss
HIV/AIDS
High Cholesterol
Hyperthyrodism
Hypothyrodism
Leukemia
Lymphoma
Lung Cancer
Breast Cancer
Colon Cancer
Prostate Cancer
Radiation Treatment
Seizures
Bone Marrow Transplant

NONE

Other_____

Past Surgical History: (please circle all that apply)

Joint Replacement, Knee (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Prostate Biopsy
Coronary Artery Bypass
Kidney Transplant
Basal Cell Carcinoma Excision
Melanoma Excision
Squamous Cell Carcinoma Excision
Appendix Removed
Bilateral Mastectomy
Gallbladder Removed
Liver Excision
Heart Catheterization
Heart Valve Replacement
Bladder Cancer
Hysterectomy
Kidney Transplant
Lumpectomy of breast (Right, Left)
Mastectomy (Right, Left, Bilateral)
Mechanical Heart Valve Replacement
Ovary Removed
Pancreas Removed
Kidney Stone Removal
Prostate Removal
Hip Replacement (Right, Left, Bilateral)
Spleen Removed
Surgical Biopsy of Skin
Kidney Removed (Right, Left)
Testicles Removed (Right, Left, Bilateral)
Heart Transplant
Liver Transplant

Other _____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay 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(s)?

_____

Medications: (Please enter all current medications)

_____
_____
_____
_____

Allergies: (Please enter all allergies)

_____
_____
_____
_____

Social History: (Please circle all that apply)

Cigarette Smoking:

Currently Smokes
Has smoked in the past
Never smoked
Former Smoker

Alcohol Use:

EtOH- None
EtOH- less than 1 drink per day
EtOH -1-2 drinks per day
EtOH -3 or more drinks per day

Other_____

Family History (Only first degree relatives)

High blood pressure_____ Diabetes_____ Heart Disease_____
Cancer_____ Lupus_____ Arthritis_____ Other_____

Preferred Pharmacy Name: _____

City or Zip code:_____