**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Legal Sex \_\_\_\_\_\_\_\_\_\_\_\_**

**HISTORY AND INTAKE FORM**

Preferred Pharmacy Name Phone # City or Zip Code

|  |
| --- |
|  |

**Medication Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Other Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Alerts (please check all that apply)**

|  |  |  |  |
| --- | --- | --- | --- |
| □ Allergy to Lidocaine | □ Blood Thinners | □ Immunosuppression | □ Rapid Heartbeat with  epinephrine |
| □ Artificial Joint within  Past two years | □ Defibrillator/Pacemaker | □ Pregnant or trying to  Get pregnant? | □ NONE |

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| □ Anxiety | □ Cancer  Type: | □ Diabetes | □ High Blood Pressure | □ Seizures |
| □ Arthritis | □ COPD | □ Renal Disease | □ HIV/AIDS | □ Stroke |
| □ Asthma | □ Coronary Disease | □ Hearing Loss | □ Leukemia/Lymphoma | □ Transplant  Type: |
| □ Atrial fibrillation | □ Depression | □ Hepatitis | □ Radiation Treatment | NONE |

**Past Medical History (please check all that apply)**

|  |  |  |
| --- | --- | --- |
| □ None | □ Gallbladder removed | □ Melanoma Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| □ Appendix Removed | □ Heart Transplant | □ Ovaries Removed – Tubal Ligation |
| □ Bladder Removed | □ Hysterectomy | □ Pancreatectomy |
| □ Breast Biopsy Right/Left/Bilateral | □ Joint Replacement Type: \_\_\_\_\_\_\_\_\_\_\_ | □ Prostate Biopsy/ TURP |
| □ Biologic Valve Replacement | □ Kidney Biopsy/ Stones | □ Rectum Resection |
| □ Cardiac Stent | □ Kidney Removed | □ Spleen Removed |
| □ Colectomy | □ Kidney Transplant | □ Testicle (s) Removed |
| □ Coronary artery Bypass | □ Liver Transplant | □ Other |

|  |  |  |  |
| --- | --- | --- | --- |
| □ Acne | □ Blistering Sunburn | □ Hay Fever/Allergies | □ Psoriasis |
| □ Actinic Keratosis | □ Dry Skin | □ Melanoma | □ Squamous Cell Skin Cancer |
| □ Basal Cell Skin Cancer | □ Eczema | □ Precancerous Moles | □ None |

|  |  |  |  |
| --- | --- | --- | --- |
| Do you wear sunscreen? | Yes No | SPF? |  |
| Do you tan in a Tanning Salon? | Yes No |  |  |

|  |  |
| --- | --- |
| Do You have a family history of Melanoma? | Yes NO Relative: |

**Medications: (Please enter all current medications, or attach list for nurse)**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  |  |  |  |
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|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Social History: (Please circle all that apply)**

**Cigarette Smoking: Alcohol Use:**

|  |  |
| --- | --- |
| Currently Smokes: Start Date | EtOH- None |
| Never smoked | EtOH- Less than 1 drink per day |
| Former Smoker | EtOH- 1-2 drinks per day |
| Total Years Smoked | EtOH- 3 or more drinks per day |

**Drug use:**

|  |
| --- |
| Drug use: Yes No |
| IV Drug Use: Yes No |

**Occupation and Workplace**

|  |
| --- |
|  |

Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_