**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_