HISTORY AND INTAKE FORM

NAME: _____ **GENDER**: M/F **DATE OF BIRTH**:____/____/____

PHARMACY: _____ **STREET**:_____ **CITY**:_____

EMAIL FOR PATIENT PORTAL: _____

PAST MEDICAL HISTORY (**CIRCLE** ALL THAT APPLY)

Anxiety
Arthritis
Asthma
Atrial Fibrillation
Enlarged Prostate (BPH)
Cerebrovascular accident
Chronic obstructive lung disease
Coronary arteriosclerosis
Depressive Disorder
Diabetes mellitus
2019-nCoV
Elevated blood pressure
End-stage blood pressure
Epilepsy
GERD
H/O: Hypertension
HIV
Hypercolesteromia
Hyperthyroidism
Hypothyroidism
Liver disease
Leukemia
Malignant lymphoma
Malignant tumor of breast
Malignant tumor of colon
Malignant tumor of lung
Malignant tumor of prostate
Radiation therapy treatment
Transplantation of bone marrow

Other:_____

PAST SURGICAL HISTORY (**CIRCLE** ALL THAT APPLY)

Abdominoperineal resection
Bilateral replacement of knee joints
Biopsy of breast
Biopsy of prostate
Coronary artery bypass graft
Entire transplanted kidney
Excision of basal cell carcinoma
Excision of melanoma
Excision of squamous cell carcinoma
H/O: colostomy
H/O: tubal ligation
H/O: appendectomy
H/O: bilateral mastectomy
H/O: cholecystectomy
H/O: colectomy
H/O: liver excision
H/O: percutaneous transluminal coronary angioplasty
Hysterectomy
Kidney biopsy
Low anterior resection of rectum
Lumpectomy of breast
Lumpectomy of left breast
Lumpectomy of right breast
Mastectomy of left breast
Mastectomy of right breast
Mechanical heart valve replacement
Oophorectomy
Pancreatectomy
Kidney stone fragmentation
Portosystemic shunt operation
Prostatectomy
Prosthetic arthroplasty bilateral hips
Splenectomy
Surgical biopsy of skin
Total nephrectomy
Total orchidectomy
Total replacement left hip
Total replacement left knee
Total replacement right hip
Total replacement right knee
Transplantation of heart
Transplantation of liver

Other:_____

SKIN DISEASE HISTORY (**CIRCLE** ALL THAT APPLY)

Acne	Eczema	Squamous cell skin cancer
Actinic Keratosis	H/O: Asthma	Sunburn
Basal Cell Skin Cancer	H/O: hay fever	None
Poison Ivy	Malignant melanoma	
Dysplastic nevus of skin	Psoriasis	

Other:_____

DO YOU WEAR SUNSCREEN? Yes No **DO YOU TAN IN TANNING SALON**? Yes No

FAMILY HISTORY

Do you have a family history of Melanoma? Yes No

If yes, which relative(s)? _____

MEDICATIONS

Please list ALL current prescription medications

_____ _____ _____ _____

_____ _____ _____ _____

ALLERGIES

Please list any allergies to **MEDICATION** only

_____ _____ _____ _____

SOCIAL HISTORY (**CIRCLE** ANY THAT APPLY)

Currently Smoke Has smoked in the past Never Smoked Drug Use Other:_____

REVIEW OF SYSTEMS: ARE YOU **CURRENTLY** EXPERIENCING ANY OF THE FOLLOWING? (**CIRCLE** ALL THAT APPLY)

Abdominal Pain	Changing Mole	Headaches	Other Rashes	Unintentional Wt Loss
Anxiety	Chest Pain	Hay Fever	Seizures	Wheezing
Bloody Stool	Cough	Joint Aches	Shortness of Breath	None
Bloody Urine	Depression	Muscle Weakness	Sore Throat	
Blurry Vision	Fever/Chills	Night Sweats	Thyroid Problems	

ALERTS: (PLEASE ANSWER **YES** OR **NO**)

Do you have a pacemaker?	YES	NO
Do you have a defibrillator?	YES	NO
Have you had artificial joints within 2 years?	YES	NO
Have you had an artificial heart valve?	YES	NO
Do you need premedication prior to procedures?	YES	NO
Do you have problems with bleeding?	YES	NO
Are you pregnant or planning to get pregnant?	YES	NO

Have you been previously diagnosed with CoVid19? YES NO

RACE (**CIRCLE** ALL THAT APPLY)

Asian American Indian Caucasian
African American Pacific Islander
Other

ETHNICITY (**CIRCLE** ALL THAT APPLY)

Hispanic Non-Hispanic Other

REASON FOR TODAYS VISIT: _____

SIGNATURE: _____ **DATE**:_____/_____/_____