History and Intake Form

Past Medical History: (Please circle all that apply)

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH
Bone Marrow Transplantation
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
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacment
None
Other ______________________________

Past Surgical History: (Please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacment, Knee (Right, Left, Bilateral)
Joint Replacment, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
None
Other ______________________________

Nurses Intake Information

Name: ______________________________ Date: ________________

Medications: (Please list all current medications)

1. ________________ 2. ________________ 3. ________________

4. ________________ 5. ________________ 6. ________________

7. ________________ 8. ________________ 9. ________________

10.________________ 11.________________ 12.________________

Allergies: (Please list all allergies to medications)

____

____

____

Primary Pharmacy: ____

Secondary Pharmacy: ____

Review of Systems: (Please circle all that apply)

- Problems with bleeding
- Problems with scarring
- Allergy to adhesive
- Allergy to lidocaine
- Rapid heart rate with epinephrine
- Allergy to topical antibiotics
- Pacemaker / Defibrillator
- Pregnant or planning a pregnancy
- Fever or chills
- Immunosuppression
- Blood thinning medication

Social History: (Please circle all that apply)

Cigarette Smoking:

- Never smoked
- Quit: former smoker
- Smoke less than daily
- Smoke daily

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)? ______________________________________

Any other family history? ______________________________________