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**History and Intake Form**

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| **Today’s Date:** |  |  | |
| **Patient Name:** |  | **Date of Birth:** |  |

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| **Medical History (please check all that apply):** | | | | | | | | |
|  | Anxiety | |  | Coronary Artery |  | Hearing Loss |  | Kidney Disease |
|  | Arthritis | |  | Disease |  | Hepatitis |  | Lymphoma/Leukemia |
|  | Artificial joints | |  | Depression |  | High Blood Pressure |  | Pacemaker/Defibrillator |
|  | Asthma | |  | Diabetes |  | HIV/AIDS |  | Radiation Treatment |
|  | Atrial fibrillation | |  | GERD/Acid Reflux |  | High Cholesterol |  | Seizures |
|  | Cancer (please list type): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |  | Hyperthyroidism |  | Stroke |
|  | COPD/Emphysema | |  | Hay Fever/Allergies |  | Hypothyroidism |  | None |
|  | Other: |  | | | | | | |

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| Surgeries (Joints, Organ or Bone Marrow Transplant, Other, please include dates): |  |
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| **Skin Disease History (please check all that apply):** | | | | | | | | |
|  | Acne |  | Dry Skin |  | Poison Ivy |  | Cancer | |
|  | Actinic Keratoses |  | Eczema |  | Precancerous Moles |  | None | |
|  | Basal Cell Skin Cancer |  | Flaking or Itchy Scalp |  | Psoriasis |  | Other: |  |
|  | Blistering Sunburns |  | Melanoma |  | Squamous Cell Skin |  |  | |

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| 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)? |  |

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| Reason for today’s visit: |  | | |
| Medications (please list ALL current medications, supplements, and over-the-counter medications, including dosages): | | |  |
|  | | | |
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| Allergies (please list all allergies to medications): | |  | |
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| Have you received a flu shot this season? |  | Yes |  | No |
| Have you ever received the pneumonia vaccine? |  | Yes |  | No |

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| **Social History (please mark one for each category):** | | | | | |
| Smoking? |  | Yes |  | No |  |

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| If former smoker: | How long did you smoke? | | | |  | When did you quit? |  |
| Alcohol? |  | Yes |  | No |  | | |
| Race: |  | | | | | | |

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| Pharmacy Name: |  | | | | |
| Address: |  | City: |  | State: |  |

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| Occupation and Hobbies: |  |

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| --- | --- |
| Email Address: |  |

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| Phone Number: |  | May we leave a detailed voice message? |  | Yes |  | No |

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| **Patient Signature:** |  | **Date:** |  |