

Patient Intake Form

Name: _____ Date of Birth: _____ Date: _____

Preferred Pharmacy

Name: _____ Phone: _____ City: _____

Preferred Laboratory to Send Specimens

Name: _____ Please note: We use CarePath for our specimens. Results may take 2-3 weeks to come back. All benign results will be posted to the patient portal. You will be contacted **ONLY** if you need to schedule treatment.

Past Medical History

Select any of the following medical conditions you currently have:

- Anxiety
- Arthritis
- Asthma
- Atrial Fibrillation
- Bone Marrow Transplant
- Enlargement of prostate
- Breast Cancer
- Colon Cancer
- COPD
- Coronary Artery Disease
- Depression
- Diabetes
- End Stage Renal Disease
- GERD

- Hearing Loss
- Hepatitis
- High Blood Pressure
- HIV / AIDS
- High Cholesterol
- Hyperthyroidism
- Hypothyroidism
- Leukemia
- Lung Cancer
- Lymphoma
- Prostate Cancer
- Radiation Treatment
- Seizures
- Stroke

- NONE
- Other

Please turn page over

Past Surgical History

Have you had any surgeries on the following organs?

- | | |
|---|--|
| <input type="checkbox"/> Heart: Pacemaker | <input type="checkbox"/> Colon: _____ |
| <input type="checkbox"/> Heart: Mechanical Valve Replacement | <input type="checkbox"/> Liver: _____ |
| <input type="checkbox"/> Breast: Lumpectomy (Right Left Bilateral) | <input type="checkbox"/> Kidney: _____ |
| <input type="checkbox"/> Breast: Mastectomy (Right Left Bilateral) | <input type="checkbox"/> Ovaries: _____ |
| <input type="checkbox"/> Gallbladder: _____ | <input type="checkbox"/> Prostate: _____ |
| <input type="checkbox"/> Joint Replacement: Knee (Right Left Bilateral) | <input type="checkbox"/> Uterus: _____ |
| <input type="checkbox"/> Joint Replacement: Hip (Right Left Bilateral) | <input type="checkbox"/> NONE |
| <input type="checkbox"/> Other: _____ | |

Skin Disease History

Have you had any of the following?

- Acne
- Actinic Keratosis
- 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?

- Mother
- Father
- Sister
- Brother
- Daughter
- Son
- Other:

If any skin cancers please list location and date skin cancer. _____

Medications

List all current medications within the chart below;

Name of medication	Unit	Route (Oral, Injection etc.)	Dosage	Form (Pill, Cream, etc)	Frequency (How often)
1.					
2.					
3.					
4.					
5.					
6.					

Can we import medications from your pharmacy? Yes No

Any Known Drug Allergies

List all drug allergies if known:

Social History

Smoking Status (please choose one):

- Current everyday smoker
- Current someday smoker
- Former smoker
- Never smoker
- Unknown if ever smoked

Number of days in the past year you had Alcohol (please choose):

- None
- 1-3 per day, on _____ occasions in a year
- 4+ per day, on _____ occasions in a year
- 5+ per day, on _____ occasions in a year

Please turn page over

Family History of Skin Cancer

Please include only first-degree relatives:

Other Medical

Have you had the Pneumonia vaccine?

Yes No

Do you have advanced care planning in place?

Yes No

Do you have a healthcare surrogate?

Yes No

If yes, Provide the name of your surrogate.

Have you had the Influenza vaccine?

Yes No

If no, please explain: Allergy or
Other _____