

# 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:

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## 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:

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## 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.

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Have you had the Influenza vaccine?

☐ Yes ☐ No

If no, please explain: Allergy or  
Other

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