History and Intake Form

I know, forms stink! But please fill in/circle as much information as possible to optimize your care. If you do not know the answer, please indicate that as "IDK".

General:

How would you like to be addressed here?: _____
Do you speak, understand, read, and write English?: Yes No
If not, what language(s) do you speak? _____
If not, do you have an interpreter available to you or with you? Yes No
Do you have any disabilities that might impact your care here? If so, please indicate that here, and tell us how we might assist you:

About you:

Are you a student? Yes No
If so, do you live locally? Yes No
Are you employed outside your home? Yes No
If so, what is the general location of your workplace? _____
How are you transported to our office? (please check):
_____ I transport myself

_____ I take public transportation or paratransit, or I hire a driver/cab

_____ I have a ride from someone I know

Please circle your current situation:
Single
Married
Unmarried but living with someone
Divorced/separated
Widowed

Do you have regular contact with family, friends, co-workers, and/or neighbors? Yes No
Who is your next of kin/emergency contact?

Name: _____

Relationship: _____

Contact information: _____
Do you have a designated health care proxy? Yes No
If so, please supply name and relationship (eg. spouse, parent, child, sibling, friend):

If you do not have a designated health care proxy, do you give us permission to communicate your health information, such as a routine lab or biopsy result, to another individual(s)? If so, please name him/her/them and the relationship (eg. spouse, significant other, parent, child, sibling, friend, other):

_____

Ethnic heritage: _____
Gender identity (please circle): Female Male Other
Sexual orientation (please circle): Heterosexual ("straight") Homosexual ("gay") Other

Prescription information:

Preferred pharmacy name: _____
Pharmacy phone number or address: _____
Do you have prescription coverage? Please check one:

_____ Yes, I have excellent coverage

_____ Yes, I am somewhat covered

_____ No, I pay all costs out of pocket

Do you prefer to have your prescriptions delivered from your local pharmacy? Yes No
Do you prefer to have your prescriptions sent to a mail order pharmacy? Yes No

Past Medical History: (please circle all that apply, and supply details)

Addiction/alcoholism:
Allergies
Anxiety
Arrhythmia/"A-fib"
Arthritis:
Asthma
Autoimmune disease:
Bleeding/blood disorders
Blindness/low vision
Cancer:
Cataracts
Cognitive impairment
Dementia
Depression
Diabetes
Fainting/vasovagal response
Genetic disease:
GI issues:
Glaucoma
Hearing Loss
Heart disease:
Hepatitis/liver disease:
High blood pressure
High cholesterol
HIV/AIDS
Hormonal disease:
Immunosuppression
Incontinence
Infections:
Kidney disease:
Leukemia/CLL
Lung disease:
Lymphoma
Mental illness:
MRSA
Neuropathy
Osteoporosis/penia
Prostate disease:
Radiation Treatment:
Seizures
STI or STD:
Stroke/TIA
TB/positive TB test
Thyroid disease:
NONE

Other medical issues, past or current:

_____

_____

Past Surgical History: (please circle all that apply and specify details/reason)

Coronary artery bypass or stent
Cosmetic surgery:
GI surgery:
Gyn surgery:
Heart valve replacement:
Joint replacement:
Lumpectomy (breast): R L
Mastectomy: R L
Nephrectomy (kidney): R L
Neurosurgery:
Pulmonary surgery:
Splenectomy:
Transplant:
Urologic surgery:
Vascular surgery:
NONE

Other surgeries:

_____

_____

Skin Disease History: (please circle all that apply)

Accutane/isotretinoin
Blistering Sunburns
Boat/beach house owner
"Dandruff"
Dry Skin
Dysplastic/atypical Moles
Eczema
Melanoma: site, depth, date
Moles
Occupational exposure
Phototherapy or radiation to skin
Poison Ivy/allergic contact dermatitis
Precancer(s)/actinic keratosis
Psoriasis
Psoriatic arthritis
Recreational exposure
Skin burn with scarring
Skin cancer (non-melanoma): site, date
Tanning salon use (past)
Toxin exposure
NONE

Other skin disease history:

_____

_____

Do you try to protect your skin from sun exposure? Yes No
Do you examine your skin regularly? Yes No
Do you tan in a tanning salon now? Yes No
Do you have a family history of Melanoma in a first degree relative (parent, sibling, child)?
Yes No
If yes, on what part of the body was it?
If yes, was it fatal? Yes No

_____

Medications: (Please simply list all current medications and supplements)

_____ _____
_____ _____
_____ _____
_____ _____

Allergies: (Please list all allergies, including foods, oral and topical medications, skin care products, positive patch tests, and all others)

_____ _____
_____ _____
_____ _____
_____ _____

Health habits: (Please circle all that apply)

Tobacco/cigarette Smoking:
Current smoker: packs per day
Smoked in the past: Packs per day? Number of years? When did you quit?
Never smoked
Chewing tobacco

Alcohol habits:
None
Rare: a few times per year
1-4 per month
1-4 per week
1-2 drinks per day
3 or more drinks per day
Drink of choice: beer white wine red wine hard liquor other

Marijuana use: (please indicate frequency)
None
Medical:
Recreational:

Other recreational drug use: (please specify)
None
Oral:
Inhaled:
Injected:
Other:

Diet: (please check all that apply)
_____ I have an unrestricted diet

_____ I follow a restricted diet: I avoid _____

_____ I eat a healthful diet, including vegetables, fruits, whole grains, nuts, seeds, beans, legumes, and other "plant foods"; I avoid sugar, white starches, fatty foods

I exercise: (please check all that apply)
_____ Not at all

_____ Periodically

_____ Very regularly

I sleep:

_____ Poorly; I wake frequently; I get less than 7 hours sleep per night

_____ Pretty well, getting 7-8 hours per night with few or no interruptions

_____ Very well, getting 8 hours at least per night of uninterrupted sleep

Family History of skin issues, allergic conditions, cancer, or genetic issues (only first degree relatives)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Review of Systems:
Difficulty with bleeding/taking blood thinners or aspirin: Yes No
Difficulty with healing: Yes No
Hormonal problem or imbalance: Yes No
Immune system problem/immunosuppressive medication: Yes No

ALERTS: (please circle all that apply)
Allergy to or irritation from adhesive
Allergy to lidocaine
Allergy to topical wound care ointments like bacitracin, Aquaphor, or Neosporin
Anxiety in medical settings
Artificial heart valve
Artificial joint replacement within past 2 yrs
Blood thinners/bleeding disorder/aspirin
C. dif history or active issue
Defibrillator implanted

Fainting/vasovagal response to medical procedures/settings
Immunosuppression (eg. Prednisone, injections, history of transplant, diabetes, CLL)
MRSA
Pacemaker implanted
Pain hypersensitivity/slow response to local anesthetic injection
Panic attacks
Require antibiotics prior to a surgical procedure
Rapid heart beat with epinephrine
Are you pregnant, or currently trying to conceive, or nursing?

Is there anything else you would like me to know about your health?