History and Intake Form

Name:_____ **Date of Birth:**_____

Past Medical History: (please list current and past medical problems)

_____

_____

Past Surgical History:

_____

_____

Skin Disease History: (please circle all that apply)

Acne	Dry Skin	
Actinic Keratoses	Eczema	Poison Ivy
Asthma	Flaking or Itchy Scalp	Precancerous Moles
Basal Cell Skin Cancer	Hay Fever/Allergies	Psoriasis
Blistering Sunburns	Melanoma	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)? _____

Medications: (Please enter all current medications)

_____

_____

Immunizations: (check if you have had) Influenza:_____ Pneumonia:_____

Allergies: (Please enter all allergies)

_____

_____

Social History: (Please circle all that apply)

Cigarette Smoking:

Currently Smoker
Former Smoker
Never Smoker

Alcohol Use:

EtOH- None
EtOH- less than 1 drink per day
EtOH -1-2 drinks per day
EtOH -3 or more drinks per day

(Continues on back side)

Review of Systems: Are you currently experiencing any of the following?
(Please check yes or no for the following)

Symptom	Yes	No
Rash		
Problems with Healing		
Problems with Bleeding		
Problems with Scarring		
Fever or Chills		
Immunosuppression		

ALERTS: (please circle all that apply)
Allergy to Adhesive
Allergy to lidocaine
Allergy to topical antibiotics
Artificial heart valve
Artificial joint replacement
Blood thinners
Defibrillator
MRSA
Pacemaker
Require antibiotics prior to a surgical procedure
Rapid heart beat with epinephrine
Are you pregnant or currently trying to get pregnant?

Family History:

Race:_____ Ethnicity: (circle one) Hispanic or non hispanic

Pharmacy Information: (required)

Preferred pharmacy Name and Location:
_____

Pharmacy Phone#: _____

City and Zip code:_____