

Patient Visit History and Intake Form at Time of Appointment

Today's Date: _____

Patient Information:

Patient Name (include first, middle initial, last): _____

Date of Birth: _____

Were you referred? Yes No

Referring Physician Name and Fax # _____

Reason for today's visit:

Past Medical History: (please select all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> NONE | <input type="checkbox"/> (Depression) | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> End Stage Renal Failure
(Kidney Disease) | <input type="checkbox"/> Inflammatory Disease of
Liver (Liver Disease) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy (Seizures) | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Gastroesophageal Reflux
Disease (GERD) | <input type="checkbox"/> Malignant Tumor of Breast |
| <input type="checkbox"/> Benign Prostatic
Hyperplasia (BPH) | <input type="checkbox"/> Hypertension (High Blood
Pressure) | <input type="checkbox"/> Malignant Tumor of Colon |
| <input type="checkbox"/> Cerebrovascular Accident
(Stroke) | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Malignant Tumor of Lung |
| <input type="checkbox"/> Chronic Obstructive Lung
Disease (COPD) | <input type="checkbox"/> Human Immunodeficiency
Virus Infection (HIV) | <input type="checkbox"/> Malignant Tumor of
Prostate |
| <input type="checkbox"/> Coronary Arteriosclerosis
(Coronary Artery Disease) | <input type="checkbox"/> Hypercholesterolemia
(High Cholesterol) | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Depressive Disorder | | <input type="checkbox"/> Bone Marrow Transplant |

Other _____

Past Surgical History: (please select all that apply)

- NONE
- Appendectomy
- Biopsy of Breast
- Biopsy of Prostate
- Cystectomy (Bladder Removal)
- Cholecystectomy (Gallbladder Removal)
- Coronary Artery Bypass Graft
- Colectomy (Colon Removal)
- Mastectomy (Breast Surgery)
- History of Orchiectomy (Testicles)
- Coronary Angioplasty
- Heart Valve replacement
- Hysterectomy (Uterus)
- Kidney Biopsy
- Kidney Stone
- Oophorectomy (Ovaries Removed)
- Pancreatectomy (Pancreas)
- Prostatectomy (Removal of Prostate)
- Splenectomy (Spleen)
- Total Nephrectomy (Removal of Kidney)
- Hip Replacement (Left Hip Joint)
- Knee Replacement (Left Knee Joint)
- Hip Replacement (Right Hip Joint)
- Knee Replacement (Right Knee Joint)
- Transplant of Kidney
- Transplant of Heart
- Transplant of Liver

Other _____

Skin Conditions: (please select all that apply)

- NONE
- Acne
- Actinic Keratoses
- Basal Cell Skin Cancer
Location _____ Year _____
- Contact Dermatitis due to
Poison Ivy
- Dry Skin
- Dysplastic Nevus of Skin
- Abnormal Mole
- Eczema
- Seasonal Allergies/Hay
Fever
- Malignant Melanoma
- Psoriasis
- Rosacea
- Seborrheic Dermatitis of
Scalp
- Skin Tanning
- Squamous Cell Carcinoma
Location _____ Year _____
- Sunburn of Second Degree

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 list all current medications, vitamins, herbs, and supplements, or attach a list)

NONE

Circle any of the following products you take – aspirin, Advil/Motrin/Ibuprofen, Aleve/Naprosyn, vitamin E, fish oil, saw palmetto, garlic, ginger, ginkgo, ginseng.

Allergies: (Please list all allergies and the type of reaction you have to each one)

NONE

Social History: (Please select all that apply)

Cigarette Smoking:

- Currently Smokes
- Never smoked
- Former Smoker

Alcohol Use:

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

IMMUNIZATION HISTORY:

- Influenza
- Pneumonia
- Shingles
- COVID-19

Occupation: _____

Preferred Language: _____

Race: _____ Ethnic Group: non-Hispanic Hispanic

(If over age 60)

Do you have a healthcare proxy in place in the event you are unable to make your own medical decisions?

YES NO

Do you have a living will? YES NO

Pharmacy Information:

Preferred pharmacy Name: _____

Phone#: _____

Location/City: _____

Primary Care Physician Information:

Name: _____

Phone #: _____

Address: _____

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

Today's Symptom	Yes	No
problems with bleeding		
problems with healing		
problems with scarring (hypertrophic or keloid)		
rash		
immunosuppression		
skin concerns		

ALERTS: (please select all that apply)

- Allergy to Adhesive
- Allergy to latex
- Allergy to lidocaine
- Allergy to topical antibiotics
- Artificial heart valve
- Artificial joint replacement
- Blood thinners
- Defibrillator
- Pacemaker
- MRSA
- Require antibiotics prior to a surgical procedure
- Rapid heartbeat with epinephrine
- Females: Are you pregnant or currently trying to get pregnant?