Intake and History Form

Name: ____ Date: _______________________

Street Address: ____ City / State: ____

Zip Code: ______________ Date of Birth: _______________ Gender: ___________________ SSN:_____________________

Home Phone: _________________________ Work Phone: ________________________ Mobile Phone: _______________________

Email Address: _______________________________________

Emergency Contact: __________________________________ Relationship: _______________ Phone:____________________

Employment Status: ☐ Employed ☐ Disabled ☐ Retired ☐ Part-Time ☐ Not Employed ☐ Student ☐ Unknown

Employer: ____ Occupation: __________________________

Address: ____ Phone:_______________________________

Preferred Language: _____________________________ Race: ________________________ Ethnic Group:______________________

By supplying my personal contact information, I authorize my health care provider to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, to notify me of a pending appointment, a missed appointment, balances due, lab results, or any other healthcare related function with an automated outreach system. I consent to detailed messages being left on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me.

______________________________ ____

Date Signed ***Signature of Patient or Patient's Representative***

Name (please print):____

Medical Contact Information:

Referring Physician:____ Phone Number: ________________________

Primary Care Physician:____ Phone Number: ________________________

Pharmacy Name:____ Phone Number: ________________________

Pharmacy Address: ____

Person With Whom We May Discuss Patient's Care (if patient is a minor or medical decisions delegated to a guardian):

Name: ______________________________ Relationship: __________________ Phone:_______________________

Insurance Information

Insurance Company:____ Policy #:_____________________________

Group #:_______________________ Policy Holder's Name *(if different from patient)*____

Policy Holder's DOB (*Required): ___ /___ /____ Policy Holder's SSN:_____________________________

Relationship to Patient: □ Self □ Spouse □ Child □ Other:

Secondary Medical Insurance (if applicable):

Insurance Company:____ Policy #:_____________________________

Group #:_______________________ Policy Holder's Name *(if different from patient)*____

Policy Holder's DOB (*Required): ___ /___ /____ Policy Holder's SSN:_____________________________

Relationship to Patient: □ Self □ Spouse □ Child □ Other:

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Past Medical History

Select any of the following medical conditions you currently have:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ NONE
- ☐ Other

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Past Surgical History

Have you had any surgeries on the following organs?

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast: Breast Biopsy
- ☐ Breast: Lumpectomy (Right, Left, Bilateral)
- ☐ Breast: Mastectomy (Right, Left, Bilateral)
- ☐ Colon (Colectomy): Colon Cancer Resection
- ☐ Colon (Colectomy): Diverticulitis
- ☐ Colon (Colectomy): Inflammatory Bowel Disease
- ☐ Colon: Colostomy
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart: Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Joint Replacement: Hip (Right, Left, Bilateral)
- ☐ Joint Replacement: Knee (Right, Left, Bilateral)
- ☐ Kidney: Kidney Biopsy
- ☐ Kidney: Kidney Stone Removal
- ☐ Kidney: Kidney Transplant
- ☐ Kidney: Nephrectomy
- ☐ Liver: Hepatectomy
- ☐ Liver: Liver Transplant
- ☐ Liver: Shunt
- ☐ Ovaries (Oophorectomy): Endometriosis
- ☐ Ovaries (Oophorectomy): Ovarian Cancer
- ☐ Ovaries (Oophorectomy): Ovarian Cyst
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate (Prostatectomy): Prostate Biopsy
- ☐ Prostate (Prostatectomy: Prostate Cancer
- ☐ Prostate (Prostatectomy): TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy

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- ☐ Skin: Squamous Cell Carcinoma
- ☐ Spleen (Splenectomy)
- ☐ Testicles (Orchiectomy)
- ☐ Uterus (Hysterectomy): Fibroids
- ☐ Uterus (Hysterectomy): Uterine Cancer
- ☐ Uterus (Hysterectomy): Cervical Cancer
- ☐ NONE
- ☐ Other: ____

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Skin Disease History

Have you had any of the following?

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Have 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
- ☐ Uncle
- ☐ Aunt
- ☐ Nephew
- ☐ Niece
- ☐ Grandmother
- ☐ Grandfather
- ☐ Grandson
- ☐ Granddaughter
- ☐ Other ____

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Medications

List all current medications:____

____

____

Allergies

List all allergies and reactions if known:____

____

____

Social History

Smoking Status (please choose one):

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

Started Smoking:

- mm/dd/yyyy ________________________________

Quit Smoking:

- mm/dd/yyyy ________________________________

Number of Packs Per Day: _________

Total Years Smoking: _____________

Alcohol Intake (please choose one):

- ☐ None
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day

Driving Status:

- ☐ Drives in the Daytime
- ☐ Drives at Night

How often do you exercise?

- ☐ Several times a day
- ☐ Once a day
- ☐ A few times a week
- ☐ A few times a month
- ☐ Never
- ☐ Other ____

What is your caffeine use?

- ☐ Several times a day
- ☐ Once a day
- ☐ A few times a week
- ☐ A few times a month
- ☐ Never
- ☐ Other ____

The above information is accurate and complete to the best of my knowledge.

______________________________ ____

Date Signed **Signature of Patient or Patient's Representative**

Name (please print):____