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Intake and History Form

Name: _____ Date: _____

Street Address: _____ City / State: _____

Zip Code: _____ Date of Birth: _____ Gender: _____

Phone Number (day): _____ Phone Number (Night): _____

Email Address: _____ Social Security: _____

Emergency Contact: _____ Relationship : _____

Phone: _____

Preferred Language: _____ Race: _____ Ethnic Group: _____

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Address: _____ City or Zip Code: _____

Primary Insurance Holder Name: _____ DOB: _____

Address: _____

Insurance Name: _____ Member ID: _____ Group #: _____

Insurance Phone Number: _____

Relation to Patient: _____

Secondary or Supplemental Insurance: _____

Insurance Name: _____ Member ID: _____ Group #: _____

Insurance Phone Number: _____



Pharmacy Name: _____ Address: _____

Phone Number: _____

**** “Failure to provide pharmacy information may result in a delay of prescriptions”**

Past Medical History

Select any of the following medical conditions you currently have:

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

Past Surgical History

Have you had any surgeries on the following organs?

- | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Appendix (Appendectomy)
<input type="checkbox"/> Bladder (Cystectomy)
<input type="checkbox"/> Breast: Breast Biopsy
<input type="checkbox"/> Breast: Lumpectomy (Right, Left, Bilateral)
<input type="checkbox"/> Breast: Mastectomy (Right, Left, Bilateral)
<input type="checkbox"/> Joint Replacement: Knee (Right, Left, Bilateral)
<input type="checkbox"/> Colon (Colectomy): Colon Cancer Resection | <input type="checkbox"/> Colon (Colectomy): Diverticulitis
<input type="checkbox"/> Colon (Colectomy): Inflammatory Bowel Disease
<input type="checkbox"/> Colon: Colostomy
<input type="checkbox"/> Heart: Mechanical Valve Replacement
<input type="checkbox"/> Heart: PTCA
<input type="checkbox"/> Joint Replacement: Hip (Right, Left, Bilateral)
<input type="checkbox"/> Joint Replacement: Knee (Right, Left, Bilateral) |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|



- Kidney: Kidney Biopsy
- Kidney: Kidney Stone Removal
- Kidney: Kidney Transplant
- Kidney: Nephrectomy
- Liver: Hepatectomy
- Liver: Liver Transplant
- Live: Shunt
- Ovaries (oophorectomy): Endometriosis
- Ovaries (Oophorectomy): Ovarian Cancer
- Ovaries (Oophorectomy): Ovarian Cyst
- Ovaries: Tubal Ligation
- Pancreas: Pancreatectomy

- Prostate (Prostatectomy): Prostate Biops

- Prostate (Prostatectomy): Prostate Cancer Prostate (Prostatectomy): TUR
 - Rectum: APR
 - Rectum: Low Anterior Resection
 - Skin: Basal Cell Carcinoma
 - Skin: Melanoma
 - Skin: Skin Biopsy
 - Skin: Squamous Cell Carcinoma

 - Spleen (Splenectomy)
 - Testicles (Orchiectomy)
 - Uterus (Hysterectomy): Fibroids
 - Uterus (Hysterectomy): Uterine Cancer
 - Uterus (Hysterectomy): Cervical Cancer
 - NONE
 - Other
-
-

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
- Hay Fever / Allergies
- Melanoma
- Poison Ivy
- Precancerous Moles

- Psoriasis
- Rosacea
- Squamous Cell Skin Cancer
- NONE
- Other

Do you wear Sunscreen?

- Yes No
If yes, what SPF? _____

Do you tan in a tanning salon?

- Yes N



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

Medications

List all current medications:

Allergies to Medications:

List all allergies and reactions if known:

Smoking Status (please choose one):

Current every day smoker

Current someday smoker

Former smoker

Never smoker

Unknown if ever smoked

Start 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
- Other

How often do you exercise?

- Once a day
- Several times a day
- A few times a week
- A few times a month
- A few times a week
- A few times a month

What is your caffeine use?

- Unspecified
- Several times a day
- Once a day
- A few times a week
- A few times a month
- Other _____
- Never

Advance Care (QM47)

Do you have a health care proxy in the event you are unable to make your own medical decisions? **Yes** **No**

Have you had your influenza vaccination within the last year? **Yes** **No**

Have you had your pneumonia vaccination? **Yes** **No**