



Medical History and Intake Form

Past Medical History: (please circle all that apply)

- | | | |
|---------------------|-------------------------|---------------------|
| Anxiety | Coronary Artery Disease | Thyroid Problems |
| Arthritis | Depression | Leukemia |
| Asthma | Diabetes | Lung Cancer |
| Atrial fibrillation | End Stage Renal Disease | Lymphoma |
| Bone Marrow | GERD | Prostate Cancer |
| Transplantation | Hearing Loss | Radiation Treatment |
| Breast Cancer | Hepatitis | Seizures |
| Colon Cancer | High Blood pressure | Stroke |
| COPD | HIV/AIDS | |
| | High Cholesterol | NONE |

Other

Past Surgical History: (please circle all that apply)

- | | |
|--|--|
| Appendix Removed | Joint Replacement within last 2 years |
| Bladder Removed | Kidney Biopsy (Nephrectomy) |
| Mastectomy (Right, Left, Bilateral) | Kidney Removed (Right, Left) |
| Lumpectomy (Right, Left, Bilateral) | Kidney Stone Removal |
| Breast Biopsy (Right, Left, Bilateral) | Kidney Transplant |
| Breast Reduction | Ovaries Removed: Endometriosis |
| Breast Implants | Ovaries Removed: Cyst |
| Colectomy: Colon Cancer Resection | Ovaries Removed: Ovarian Cancer |
| Colectomy: Diverticulitis | Prostate Removed: Prostate Cancer |
| Colectomy: IBD | Prostate Biopsy |
| Gallbladder Removed | TURP (Prostate Removal) |
| Coronary Artery Bypass | Spleen Removed |
| Mechanical Valve Replacement | Testicles Removed (Right, Left, Bilateral) |
| Biological Valve Replacement | Hysterectomy: Fibroids |
| Heart Transplant | Hysterectomy: Uterine Cancer |
| Joint Replacement, Knee (Right, Left, Bilateral) | |
| Joint Replacement, Hip (Right, Left, Bilateral) | NONE |
| Other | |



Precision Skin Care, LLC.
1709 W. 7th Street
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Skin Disease History: (please circle all that apply)

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

Allergies: (Please enter all allergies)

Social History: (Please circle all that apply)

Cigarette Smoking:

- Currently Smokes
- Has smoked in the past
- Never smoked
- Former 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



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Family History (Only first degree relatives)

Preferred Language: _____

Race: _____ Ethnic Group: _____

Preferred Pharmacy Name: _____

Phone#: _____

City or Zip code: _____

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?