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**History and Intake Form**

**NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **DATE OF BIRTH:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Care Physician or Referring Physician:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason for visit:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Skin Disease History**: (Any new skin diagnoses or skin pathology not at this office)

**Pharmacy:**

Name:

Street: Zip Code:

**Medications**: (Please enter all current medications, including dose and frequency)

**□ *No medications***

**Medication Allergies**: (Please enter all medication allergies)

**□ *No known medication allergies***

**Medical History**: (please circle all that apply)

Anxiety

Arthritis

Artificial joints

Bone Marrow Transplantation

Cancer (type?)

Dementia

Depression

Diabetes

Hepatitis

Hypertension

HIV/AIDS

Hyperthyroidism

Hypothyroidism

Pacemaker

Valve Replacement

***None***

**Surgical History**: (please circle all that apply)

Mechanical Valve Replacement

Biological Valve Replacement

Joint Replacement within last 2 years

Organ Transplant

***None***

**Family Health History:** (parents, siblings, or children) *Please indicate which relative & type of*

 *disease*

Any history of melanoma?

Any history of skin disease?

**Social History:** (please circle one){*As part of Obamacare, the following questions are now required*}

Cigarette Smoking: Never smoked

 Quit: former smoker

 Smokes less than daily Smokes daily

Language:

 English

 Spanish

 Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Ethnicity:

 Hispanic/Latino

Alcohol Use:

 YES

 Less than 1 drink/day

 1-2 drinks/day

 3 or more drinks/day

 NO

How many times in the past year have you had 5 or more drinks in a day (for men younger than 65), or 4 or more drinks in a day (for women or men older than 65)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Non-Hispanic/Latino

Race:

 White

 Black/African American

 Asian

 American Indian or Native Alaskan

 Native Hawaiian/Pacific Islander

How often do you exercise?

 Once a day

 A few times a week

 A few times a month

 Never

What is your caffeine use?

 Once a day

 A few times a week

 A few times a month

 Never