**Medical Intake Form**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_ Height\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_

Primary Care Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Latex ­­\_\_ Y \_\_ N

Reason for Visit: ­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Problems or Conditions:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Details |
| Have you ever had skin cancer? |  |  |  |
| Have you ever had melanoma? |  |  |  |
| History of any skin disorders? |  |  |  |
| History of tanning bed use? |  |  |  |
| History of blistering sun burns? |  |  |  |
| Anyone in the family with any skin cancer or melanoma? |  |  |  |
| Anyone in the family with any skin problems? |  |  |  |

(Women): Are you pregnant? Yes \_\_ No \_\_\_ Planning to become pregnant? Yes \_\_ No \_\_\_

Current Medications (including supplements, herbs, vitamins): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_\_\_\_\_\_

**Surgical Procedures you have had:** ­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­

**Heart valve replacement** \_\_\_ Yes (Year \_\_\_\_\_\_ ) \_\_\_ No **Knee Replacement** \_\_\_ Yes (Year \_\_\_\_\_\_ ) \_\_\_ No

Do you smoke? \_\_\_ Yes \_\_\_ No If YES, how many cigarettes per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol? \_\_\_ Yes \_\_\_ No If YES, how many drinks per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you, or have you used IV drugs? \_\_\_ Yes \_\_\_ No What is your occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Review of Systems:** Current or past problems with:

|  |  |  |
| --- | --- | --- |
|  | Yes | No |
| Thyroid |  |  |
| Lungs |  |  |
| Diabetes |  |  |
| Eyes |  |  |
| **Pacemaker** |  |  |
| Kidneys |  |  |
| Skin |  |  |
| Ears/Nose |  |  |
| Throat/Mouth |  |  |
| Stomach/Bowel |  |  |
| Joints |  |  |
| Muscles |  |  |

|  |  |  |
| --- | --- | --- |
|  | Yes | No |
| General Health |  |  |
| Allergic Reactions |  |  |
| Blood/Bleeding Disorder |  |  |
| Liver |  |  |
| Psychological Disorder |  |  |
| Heart |  |  |
| **Fainting with Medical Procedures** |  |  |
| Asthma |  |  |
| Seizures |  |  |
| Artificial Joints |  |  |
| Heart Valves |  |  |
| Dialysis |  |  |

Reviewed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_