MEDICAL INTAKE QUESTIONNAIRE

Name: ­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_/\_\_/\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OK to leave message on this number? Yes No

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please send e-mails for events/promos Yes No

Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have any of the following:**

Yes No

Cardiac pacemaker or defibrillator: ☐ ☐

Take antibiotics for dentist: ☐ ☐

On blood thinners: ☐ ☐

Artificial joint or heart valves: ☐ ☐

HIV/AIDS: ☐ ☐

Hepatitis B or C: ☐ ☐

History of severe bleeding: ☐ ☐

**Personal medical History:**

Self Family

Cancer (type): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐

Thyroid: ☐ ☐

High blood pressure: ☐ ☐

Diabetes: ☐ ☐

Heart disease/Heart attack: ☐ ☐

Blood vessel disorder: ☐ ☐

Blood clots: ☐ ☐

Asthma: ☐ ☐

Other medical problems:

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

**Current medications:**

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

**Medication allergies:**

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

**Skin history:**

Personal history of skin cancer: Yes No

If yes, circle what type:

Basal Cell Carcinoma

Squamous Cell Carcinoma

Melanoma

Family history of skin cancer: Yes No

If yes, circle what type:

Basal Cell Carcinoma

Squamous Cell Carcinoma

Melanoma

**MISC:** Yes No

Difficulty with wound healing: ☐ ☐

Keloids or abnormal scarring: ☐ ☐

Blistering sunburns: ☐ ☐

History of tanning bed use: ☐ ☐

Current tanning bed use: ☐ ☐

Eczema: ☐ ☐

Psoriasis: ☐ ☐

History of radiation exposure: ☐ ☐

Do you wear sunscreen? ☐ ☐

Accutane in the past 12 months: ☐ ☐

**Social history:**

Marital status:

Single Married Divorced Domestic partner

Separated Widowed

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tobacco use:

Smoking ☐ Chewing Tobacco ☐

Daily amount: \_\_\_\_\_\_\_\_\_\_\_\_ Years :\_\_\_\_\_\_\_

Alcohol use:

Yes ☐ No ☐ Occasional ☐

Amount: \_\_\_\_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_\_

**Female:** Nursing or pregnant