

Patient Medical History Intake Form

Patient name	Date of birth	Today's date
<input type="text"/>	<input type="text"/>	<input type="text"/>

Reason for today's visit

Primary care provider	Referring physician (if applicable)
<input type="text"/>	<input type="text"/>

Preferred pharmacy	Pharmacy address and phone number
<input type="text"/>	<input type="text"/>

Do you authorize us to upload your prescriptions from your pharmacy? ☐ Yes ☐ No

Medical history (check any conditions you are currently being treated for or have had in the past) ☐ None

- | | | |
|---|--|--|
| ☐ Anxiety disorder | ☐ Arthritis | ☐ Asthma |
| ☐ Atrial fibrillation | ☐ Cerebrovascular accident (stroke) | ☐ COPD |
| ☐ Coronary artery disease | ☐ Depressive disorder | ☐ Diabetes mellitus |
| ☐ Elevated blood pressure | ☐ End-stage renal disease | ☐ Epilepsy (seizures) |
| ☐ History of hypertension | ☐ Hepatitis B | ☐ Hepatitis C |
| ☐ History of radiation therapy | ☐ HIV | ☐ Hypercholesterolemia (high cholesterol) |
| ☐ Hyperthyroidism | ☐ Hypothyroidism | ☐ Immunosuppression |
| ☐ Leukemia | ☐ Malignant lymphoma | ☐ Malignant tumor of breast |
| ☐ Malignant tumor of colon | ☐ Malignant tumor of prostate | ☐ Transplantation of bone marrow |

Other

Past surgical history (check all past procedures or surgeries) ☐ No past procedures or surgeries

- | | | |
|---|---|--|
| ☐ Coronary artery bypass | ☐ Excision of basal cell carcinoma | ☐ Excision of melanoma |
| ☐ Excision of squamous cell carcinoma | ☐ History of artificial joint | ☐ History of appendectomy |
| ☐ History of cholecystectomy (gallbladder removed) | ☐ History of colectomy | ☐ Hysterectomy |
| ☐ Mechanical heart valve replacement | ☐ Thyroidectomy | ☐ Transplant of kidney |
| ☐ Transplantation of heart | ☐ Transplantation of liver | |

Other

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Skin conditions and skin disease history (check all that apply)☐ None☐ Acne☐ Actinic keratosis☐ Basal cell skin cancer☐ Contact dermatitis☐ Dysplastic nevus moles☐ Eczema☐ History of hay fever / allergies☐ Melanoma☐ Psoriasis☐ Rosacea☐ Squamous cell skin cancer☐ Sunburn of second degree

Other

Do you wear sunscreen? ☐ Yes ☐ No If yes, what SPF?Do you or have you tanned in a tanning bed? ☐ Yes ☐ NoDo you have a family history of melanoma? ☐ Yes ☐ No If yes, which relative(s)?**Current medications** (include non-prescription products and supplements)☐ None

#	Medication	Strength (dosage)	Frequency	Route (oral, topical, etc.)	Diagnosis (why do you take this medication?)
1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
6	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
7	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Allergies (include medication, food, latex and environmental allergies)☐ No known allergies

#	Allergy	Type of reaction (check all that apply)
1	<input type="text"/>	☐ Itching ☐ Swelling ☐ Hives ☐ Rash ☐ Difficulty breathing ☐ Anaphylaxis Other: <input type="text"/>
2	<input type="text"/>	☐ Itching ☐ Swelling ☐ Hives ☐ Rash ☐ Difficulty breathing ☐ Anaphylaxis Other: <input type="text"/>
3	<input type="text"/>	☐ Itching ☐ Swelling ☐ Hives ☐ Rash ☐ Difficulty breathing ☐ Anaphylaxis Other: <input type="text"/>
4	<input type="text"/>	☐ Itching ☐ Swelling ☐ Hives ☐ Rash ☐ Difficulty breathing ☐ Anaphylaxis Other: <input type="text"/>

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Are you a tobacco smoker?

☐ Current smoker ☐ Former smoker ☐ Never

Alcohol intake

☐ None ☐ 1 or less per day ☐ 1-2 per day
☐ 3 or more per day

Patients 65 years and older: advance care plan (if you are 65 or older, please answer these questions)

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

Designee name

Designee phone number

Do you have a living will? ☐ Yes ☐ No

Have you had a pneumonia vaccine? ☐ Yes ☐ No

Patients turning 13 this year: adolescent immunizations (if the patient turns 13 this year, please answer these questions)

Has the patient had a meningococcal vaccine on or between the patient's 11th and 13th birthdays? ☐ Yes ☐ No

Has the patient had a tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) on or between the patient's 10th and 13th birthdays?

☐ Yes ☐ No

Has the patient completed the HPV vaccine series on or between the patient's 9th and 13th birthdays? ☐ Yes ☐ No

If you answered no to any of the questions above, did the patient have an anaphylaxis reaction due to one of these vaccines at any time on or before the patient's 13th birthday?

☐ Yes ☐ No

Review of systems (check all that apply)

☐ None

☐ Problems with bleeding / bruising

☐ Problems with scarring

☐ Skin rashes

☐ Headaches

☐ Seasonal allergies

☐ Unintentional weight loss

☐ Fever or chills

☐ Night sweats

☐ Abdominal pain

☐ Bloody stool

☐ Bloody urine

☐ Joint aches

☐ Muscle weakness

Alerts (check all that apply)

☐ None

☐ Allergy to adhesive / tape

☐ Allergy to latex

☐ Allergy to lidocaine

☐ Allergy to topical antibiotic ointment

☐ Artificial heart valve

☐ Artificial joints (within past two years)

☐ Blood thinners

☐ Currently breastfeeding

☐ Defibrillator / pacemaker

☐ Hepatitis B or C

☐ HIV

☐ MRSA

☐ Premedication prior to procedures

☐ Pregnancy or planning a pregnancy

☐ Rapid heartbeat with epinephrine

Questions or need help with this form? Call 501-817-3923 (TTY: 800-285-1131) or text 501-550-9095. We can provide large print, read the form aloud with you, or help you fill it out, free of charge.