HISTORY AND INTAKE FORM
(PLEASE PRINT)

Name: _____ DOB: _____

Occupation: _____

Pharmacy & Address:

_____

_____

Past Medical History / Alerts: (Please circle all that apply)

ALERTS:

Artificial Joint
Artificial Heart Valve
Blood Thinners
Defibrillator
GI Upset w/ Antibiotics
HIV / Hepatitis
Immunosuppressant
Pacemaker
Pre-meds prior to procedure
Pregnant / Nursing
Yeast Infection w / Antibiotics

MEDICAL HISTORY:

Anxiety
Arthritis
Rheumatoid Psoriatic Arthritis
Asthma
Atrial Fibrillation
Bone Marrow Transplant
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
HIV/AIDS
Hyper or Hypotension
Hypercholesterolemia
Hyper or Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Polycystic Ovarian Disease
Ovaries Removed
Prostate Cancer
Prostate Issues
Radiation Treatment
Seizures
Stroke
None

Other: _____

MAJOR SURGERIES:

Hysterectomy
Joint Replacement
Mitral Valve Replacement
Kidney Surgeries
Mastectomy
Breast Surgeries
Other:
_____
_____
_____

SKIN DISEASE HISTORY:

Acne
Actinic Keratosis
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever / Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Rosacea
Squamous Cell Skin Cancer

Other: _____

THIS IS A DOUBLE-SIDED FORM, PLEASE COMPLETE BOTH SIDES

MEDICATIONS:
(Please list all current medications and doses)

_____
_____
_____
_____
_____
_____

ALLERGIES:
(Please list all allergies and associated reactions)

_____
_____
_____
_____
_____
_____

SOCIAL HISTORY: *(Please circle all that apply)*

Tobacco	Alcohol	Drugs
Current Smoker	Social Only	None
- Daily	< 1 drink daily	Other: _____
- Not Daily	1-2 drinks daily	_____
Has smoked in the past	≥ 3 drinks daily	_____
Has never smoked	None	

FAMILY HISTORY: *(Please circle all that apply)*

High Blood Pressure	Lupus	Cancers: _____
High Cholesterol	Psoriasis	_____
Diabetes	Melanoma	_____
		Family Member:
		_____

Family History of Basal Cell Skin Cancer? ☐ Yes ☐ No If yes, who: _____

Family History of Squamous Cell Skin Cancer? ☐ Yes ☐ No If yes, who: _____

Family History of Melanoma Skin Cancer? ☐ Yes ☐ No If yes, who: _____

Did you get a Flu shot during the current flu season? □ Yes □ No

(initial here _____) ***I authorize AAID to test my blood for hepatitis and HIV if, in their opinion, an employee has suffered an exposure incident as a result of my treatment, as defined by the Occupational Safety and Health Administration.***

I certify that I understand the above and that the information I have given is correct to the best of my knowledge.

_____ _____

Signature (parent/guardian if minor) **Date (MM/DD/YY)**