SOBEL & SOFMAN, M.D., P.A.

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Intake and History Form

Name: ______________________ Date: ______________

Street Address: ______________________ City/State: ______________

Zip Code: __________ Date of Birth: ______________ Gender: ______________

Phone Number(day): ______________ Phone Number(evening): ______________

Email address: ______________________________

Emergency Contact: ______________________________

Preferred Language: __________Race: __________ Ethnic Group: __________

Primary Care Provider: ______________ Referred by: ______________

Preferred Pharmacy

Name: ______________ Address: ______________________

City/Zip Code: ______________________

Phone Number: ______________________

Medical History: select any of the following medical conditions that you have or have had:

☐Anxiety	☐Diabetes	☐Lung Cancer
☐Arthritis	☐End Stage Renal Disease	☐Lymphoma
☐Asthma	☐GERD	☐Prostate Cancer
☐Atrial Fibrillation	☐Hearing Loss	☐Radiation Treatment
☐Bone Marrow Transplant	☐Hepatitis	☐Seizures
☐Benign Prostatic Hypertrophy	☐Hypertension	☐Stroke
☐Breast Cancer	☐HIV/AIDS	☐None
☐Colon Cancer	☐Hypercholesterolemia	☐Other
☐COPD	☐Hyperthyroidism	______________
☐Coronary Artery Disease	☐Hypothyroidism	______________
☐Depression	☐Leukemia	______________

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Past Surgical History: Have you had any surgery on the following organs?

☐Appendix (appendectomy)	☐Ovaries (oophorectomy: endometriosis)
☐Bladder (cystectomy)	☐Ovaries (oophorectomy: ovarian cancer)
☐Breast (breast biopsy)	☐Ovaries (oophorectomy: ovarian cyst)
☐Breast (lumpectomy: right, left, bilateral)	☐Ovaries (tubal ligation)
☐Breast (mastectomy: right left bilateral)	☐Pancreas (pancreatectomy)
☐Colon (colectomy, colon cancer resection)	☐Prostate (biopsy)
☐Colon (colectomy, diverticulitis)	☐Prostate (prostatectomy: prostate cancer)
☐Colon (colectomy, inflammatory bowel disease)	☐Prostate (prostatectomy: TURP)
☐Colon (colostomy)	☐Rectum (APR)
☐Gallbladder (cholecystectomy)	☐Rectum (low anterior resection)
☐Heart (coronary artery bypass)	☐Skin (basal cell carcinoma)
☐Heart (heart transplant)	☐Skin (melanoma)
☐Heart (valve replacement)	☐Skin (skin biopsy)
☐Heart (angioplasty)	☐Skin (squamous cell carcinoma)
☐Joint replacement (hip: right, left, bilateral)	☐Spleen (splenectomy)
☐Joint replacement (knee: right, left, bilateral)	☐Testicles (orchiectomy)
☐Kidney (biopsy)	☐Uterus (hysterectomy: fibroids)
☐Kidney (kidney stone removal)	☐Uterus (hysterectomy: uterine cancer
☐Kidney (transplant)	☐Uterus (hysterectomy: cervical cancer
☐Kidney (nephrectomy)	☐NONE
☐Liver (hepatectomy)	☐Other
☐Liver ((transplant)	____________________
☐Liver (shunt)	____________________
	____________________

Intake and History Form

Skin Disease History

Have you had any of the following?

☐Acne

☐Actinic Keratoses

☐Asthma

☐Basal Cell Carcinoma

☐Blistering sunburns

☐Dry skin

☐Eczema

☐Flaking or itchy scalp

☐Hay Fever/Allergies

☐Melanoma

☐Poison Ivy

☐Precancerous moles/Dysplastic Nevi

☐Psoriasis

☐Squamous Cell Carcinoma

☐Vitiligo

☐NONE

☐Other

____

____

Do you wear sunscreen?

☐Yes ☐No

If yes, what SPF? _____________

Do you tan in a tanning salon?

☐Yes ☐No

Do you have a family history of melanoma?

☐Yes ☐No

If yes, which relative?

☐Mother

☐Father

☐Sister

☐Brother

☐Daughter

☐Son

☐Uncle

☐Aunt

☐Nephew

☐Niece

☐Grandmother

☐Grandfather

☐Grandson

☐Granddaughter

☐Other

____

____

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Medications

Please list all current medications, including over the counter products, vitamins, and supplements

______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

Allergies

Please list all allergies and types of reactions, if known

____

____

____

Social History

Smoking Status (please choose one)

☐Current every day smoker
☐Current some day smoker
☐Former smoker
☐Never smoker
☐Unknown if ever smoked

Started smoking

Mo/Yr ______________________

Quit smoking

Mo/Yr ______________________

Number of packs/day ______________

Total years smoking ______________

Alcohol intake (please choose one)

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

How many times in the past year have you had more than 5 drinks in a day for a man, or 4 for a woman or anyone over 65? _________

Driving status

☐Drives only in the daytime
☐Drives at night

How often do you exercise?

☐Unspecified
☐Several times a day
☐Once a day
☐A few times a week
☐A few times a month
☐Never
☐Other ______________________

What is your caffeine use?

☐ Unspecified
☐ Several times a day
☐ Once a day
☐ A few times a week
☐ A few times a month
☐ Never
☐ Other ______________________

Intake and History Form

Occupation and workplace

____

____

Place of residence

____

Family History (anything of importance not listed above, first degree relatives only)

____

____

Review of Systems: Do you have any of the following? Please check yes or no

Symptom	Yes	No
Allergy to Adhesive(rash)		
New hair growth on face, chest , or abdomen		
New moles		
Problems with bleeding/easy bruising		
Problems with healing		
Problems with scarring (keloids or hypertrophic scars		
Rash		
Sensitivity to sunlight		
Significant changes in existing moles		
Significant hair loss		
Significant persistent or intermittent burning of the skin		
Significant persistent or intermittent itching of the skin		
Currently having menstrual periods		
Irregular menstrual cycle		
Hay fever		
Immunosuppression		
Palpitations		
Unintentional weight loss		
Thyroid problems		
Joint aches		
Anxiety		
Depression		

Intake and History Form

Alerts

Please check yes or no for the following:

Symptom	Yes	No
Allergy to lidocaine- itching		
Allergy to lidocaine- palpitations		
Allergy to lidocaine- sweating		
Allergy to topical antibiotics		
Allergy to latex		
Artificial heart valve		
Artificial joints within the past 2 years		
Blood thinners		
Defibrillator		
MRSA infection		
Pacemaker		
Becomes vasovagal (faints from needles, etc)		
Personal history of malignant melanoma		
Needs premedication prior to procedures		
Rapid heartbeat with epinephrine		
Pregnant or planning pregnancy soon		