Craig W. Colville, M.D., F.A.C.S.

Medical History and Intake Form

Patient Name | **Date of Birth / Age** | **Today's Date**

Surgeries: Please list any surgeries you have had in the past (ex. Lasik eye, tonsils, gallbladder, hysterectomy, wisdom teeth, etc.). Please list any cosmetic surgeries as well (please use an extra sheet if needed):

Surgery Type	Year	Surgery Type	Year

Do you have any history of anesthesia problems with surgery? ☐ **No** ☐ **Yes** **(if yes, please explain):**

_____

_____

Medical History: For what medical or mental conditions have you previously been or are currently being treated? (please check all that apply, use an extra sheet if more "details" are needed):

	Yes	Details		Yes	Details
- Pt denies any past medical history			High Cholesterol		
Acid Reflux/GERD			HIV/AIDS		
ADD/ADHD			Kidney Failure		
Anxiety			Lasik Surgery		
Arthritis			Leukemia		
Artificial Joints			Neck Pain		
Back Pain			Neurologic - Seizures		
Bleeding/Blood Disorders			Neurologic - Stroke/TIA		
Breast Cancer			Prostate Disease/Cancer		
Cancer			Prosthetic Device (Implants)		
Chemotherapy			Radiation		
Cold Sores/Herpes			Respiratory - Asthma		
Diabetes - Diet control			Respiratory - COPD		
Diabetes - Insulin Dependent			Respiratory - other		
Diabetes - NonInsulin Dependent			Skin Cancer - Basal Cell		
Fibromyalgia/Chronic Fatigue			Skin Cancer - Melanoma		
Headaches/Migraines			Skin Cancer - Squamous Cell		
Hearing Loss			Skin Disease/Disorder		
Heart Disease - Arrhythmia/A-Fib			STD		
Heart Disease - history MI			Substance Abuse		
Heart Disease - other			Thyroid Disorder		
Heart Disease - Pacemaker/Defib			Tuberculosis		
Heart Disease - stents			Ulcers		
Heart Murmur/MVP			OTHER -		
Hepatitis			OTHER -		
High Blood Pressure			OTHER -		

PLEASE COMPLETE REVERSE SIDE

Patient Name **Date of Birth / Age**

Female Questions	#	Yes	No	N/A
Number of pregnancies?				
Number of live births?				
Are you currently pregnant or lactating?				
Number of children breast-fed?				

Allergies: (Including: tape, latex, medications, etc. - please use an extra sheet if needed.)

☐ No Known Allergies ☐ No Known Drug Allergies

Allergy	**Reaction** (anaphylaxis, hives, rash, difficulty breathing, nausea, vomiting, etc.)

Medications: List all medications you are taking. (Please include vitamins, supplements, herbals, steroids, prescribed medications and any over-the-counter medications such as: aspirin, ibuprofen or other NSAIDS; use an extra sheet if needed.)

Medication	Dose/Strength	For what reason/condition are you taking?

Family History: Please list any medical conditions that have existed in your immediate family (blood relations) - please indicate if maternal or paternal:

	Yes	Family Member		Yes	Family Member
- Pt denies any contributing family history			Kidney Disease		
Anesthesia Problems			Leukemia		
Autoimmune Disorders			Liver Disease		
Blood/Bleeding Disorder			Lung Cancer		
Brain Tumor			Malignant Hyperthermia		
Breast Cancer			OTHER		
Diabetes			Other Cancer		
Drug Allergies			Ovarian Cancer		
Endocrine Disease			Prostate Cancer		
Heart Disease			Skin Cancer		
High Blood Pressure			Stroke/TIA		
High Cholesterol			Substance Abuse		

Patient Name **Date of Birth / Age**

Social History:

Alcohol	☐	Denies alcohol use
	☐	Admits alcohol use socially
	☐	Admits alcohol use daily
	☐	Recovering alcoholic
Illegal Drugs	☐	Denies using illegal drugs
	☐	Admits to using illegal drugs
Tobacco	☐	Denies tobacco use
	☐	Current tobacco user
	☐	Current smokeless tobacco user (i.e. chew, snuff)
	☐	Tobacco use unknown, reason not specified

Height _____ **Current Weight** _____

If you are being seen for a lesion, mole or skin cancer, please fill out the following:

Lesion / Skin Cancer: Size: _____ Present How Long? _____

Location / Site: _____

When did symptoms start? _____

How has it changed? _____

Biopsy done? _____ What doctor? _____

Sun exposure? _____ History of skin cancer: _____

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