

THE DERMATOLOGY AND MOHS SURGERY CENTER - MEDICAL HISTORY

Name: _____ Occupation: _____

DOB: ___/___/___ Age: _____ Sex: _____ Referred by: _____

Primary Care Physician: _____

Reason for today's visit: _____ Area(s) of body? _____

How have you treated? _____ When was first occurrence? _____

PAST MEDICAL HISTORY: (circle all that apply)

Anxiety	Diabetes	Hypothyroidism (low)
Arthritis	End Stage Renal Disease	Leukemia
Asthma	GERD	Lung Cancer
Atrial Fibrillation	Hearing Loss	Lymphoma
Bone Marrow Transplant	Hepatitis	Pneumonia Vaccine
Breast Cancer	High Blood Pressure	Prostate Cancer
Colon Cancer	HIV/AIDS	Radiation Treatment
COPD	High Cholesterol	Seizures
Coronary Artery Disease	Hyperthyroidism (high)	Stroke
Depression		NONE

PAST SURGICAL HISTORY: (please list): NONE

SKIN DISEASE HISTORY: (circle all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratosis	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Carcinoma	Hay Fever/Allergies	Squamous Cell Carcinoma
Blistering Sunburns	Melanoma	Cancer
Other: _____		NONE

Do you wear sunscreen? YES NO If yes, what SPF? _____ Do you tan indoor/outdoor? YES NO

Do you have a family history of melanoma? YES NO If yes, which relative(s)? _____

MEDICATIONS: (Please list all current medications)

OVER→

ALLERGIES: (please list all allergies to medications)

SOCIAL HISTORY:

Do you smoke? Yes__ No__ If yes, how much? _____ **If no**, have you smoked in the past? Yes__ No__

Do you use IV drugs? Yes__ No__ If yes, what type? _____ **If no**, have you used in the past? Yes__ No__

Do you drink alcohol? Yes__ No__ If yes, _____drinks per day/week/month

Do you have a family history of cancer (other than skin)? YES NO If yes, type of cancer(s)? _____

Which relative(s)? _____

REVIEW OF SYSTEMS: Do you **CURRENTLY** have any of the following? Circle **Y** for **YES** or **N** for **NO**

GENERAL:

Fever Y N
Weight Loss Y N

Blurred Vision Y N
Sore Throat Y N

ENDOCRINE:

Thyroid Problems Y N

CARDIOVASCULAR:

Swelling of Extremities Y N

GASTROINTESTINAL:

Abdominal Pain Y N
Bloody Stool Y N
Bloody Urine Y N

MUSCULOSKELETAL:

Joint Pain Y N
Muscle Pain or Weakness Y N

NEUROLOGICAL:

Headaches Y N
Seizures Y N

RESPIRATORY:

Chronic Cough Y N
Shortness of Breath Y N
Wheezing Y N

HEMATOLOGY:

Abnormal Bleeding Y N

INTEGUMENTARY:

Bruising Y N
Problems with Scarring Y N
Rash Y N

PSYCHIATRIC:

Anxiety Y N
Depression Y N

ALERTS: (circle all that apply)

- | | |
|--|------------------------------------|
| Allergy to Adhesive | Allergy to Lidocaine |
| Allergy to Topical Antibiotics | Artificial Heart Valve |
| Artificial Joint Replacement | Blood Thinners |
| Defibrillator | MRSA |
| Pacemaker | Pregnant or trying to get pregnant |
| Latex Allergy | Breastfeeding |
| Rapid heart with epinephrine | |
| Require antibiotics prior to a dental/surgical procedure | Reason: _____ |

Race: _____ or DECLINE Ethnic Group: _____ or DECLINE

Preferred Pharmacy Name/Location: _____

Preferred Language: ENGLISH or Other: _____

PATIENT SIGNATURE: _____ Staff Initials _____