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	Depression	Hypothyroidism (low)
Arthritis	Diabetes	Leukemia
Asthma	End Stage Renal	Lung Cancer
Atrial Fibrillation	Disease GERD	Lymphoma
Bone Marrow Transplant	Hearing Loss	Pneumonia Vaccine
Breast Cancer	Hepatitis	Prostate Cancer
Colon Cancer	High Blood Pressure	Radiation Treatment
COPD	HIV/AIDS	Seizures
Coronary Artery Disease	High Cholesterol	Stroke
Covid-19 Vaccine	Hyperthyroidism (high)	NONE

PAST SURGICAL HISTORY: (please list): NONE

____

____

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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	**NEUROLOGICAL:**	
Weight Loss	Y N	Headaches	Y N
		Seizures	Y N
Blurred Vision	Y N	**RESPIRATORY:**	
Sore Throat	Y N	Chronic Cough	Y N
ENDOCRINE:		Shortness of Breath	Y N
Thyroid Problems	Y N	Wheezing	Y N
CARDIOVASCULAR:		**HEMATOLOGY:**	
Swelling of Extremities	Y N	Abnormal Bleeding	Y N
GASTROINTESTINAL:		**INTEGUMENTARY:**	
Abdominal Pain	Y N	Bruising	Y N
Bloody Stool	Y N	Problems with Scarring	Y N
Bloody Urine	Y N	Rash	Y N
MUSCULOSKELETAL:		**PSYCHIATRIC:**	
Joint Pain	Y N	Anxiety	Y N
Muscle Pain or Weakness	Y N	Depression	Y N

ALERTS: (circle all that apply)

Allergy to Adhesive
Allergy to Topical Antibiotics
Artificial Joint Replacement
Defibrillator
Pacemaker
Latex Allergy
Rapid heart with epinephrine
Require antibiotics prior to a dental/surgical procedure

Allergy to Lidocaine
Artificial Heart Valve
Blood Thinners
MRSA
Pregnant or trying to get pregnant
Breastfeeding
Reason: ________________________________

Race: ___________________ or DECLINE Ethnic Group: _________________________ or DECLINE

Preferred Pharmacy Name/Location: ____

Preferred Language: ENGLISH or Other: ________________________________

PATIENT SIGNATURE: ____ Staff Initials _______________