DERMATOLOGY AND MOHS SURGERY CENTER - MEDICAL HISTORY

Name: _____ Occupation: _____

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

Primary Care Physician: _____

Preferred Pharmacy: _____ Email Address: _____

Primary Insurance: _____ Secondary: _____

PAST MEDICAL HISTORY: (circle all that apply)

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

PAST SURGICAL HISTORY: (please list): NONE

_____

_____

SKIN DISEASE HISTORY: (circle all that apply)

Acne
Actinic Keratosis
Asthma
Basal Cell Carcinoma
Blistering Sunburns
Other: _____
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Carcinoma
Cancer
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/dose) – Or give a copy to the front desk staff to enter in manually

_____

_____

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 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
Blurred Vision	Y N	Seizures	Y N
Sore Throat	Y N	**RESPIRATORY:**	
ENDOCRINE:		Chronic Cough	Y N
Thyroid Problems	Y N	Shortness of Breath	Y N
CARDIOVASCULAR:		Wheezing	Y N
Chest Pain	Y N	**HEMATOLOGY:**	
Swelling of Extremities	Y N	Abnormal Bleeding	Y N
GASTROINTESTINAL:		**INTEGUMENTARY:**	
Abdominal Pain	Y N	Problems with Healing	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
Allergy to Lidocaine
Artificial Heart Valve
Blood Thinners
MRSA
Pregnant or trying to get pregnant
Breastfeeding

Require antibiotics prior to a dental/surgical procedure Reason: _____

Race: _____ or DECLINE Ethnic Group: _____ or DECLINE

Preferred Language: ENGLISH or Other: _____

PATIENT SIGNATURE: _____ Staff Initials _____