

Date: ____/____/____ Reason for today's visit: _____

Patient name: _____ Phone # _____

Community Name: _____ Date of Birth: ____/____/____

Primary Insurance: _____ ID # _____

Secondary Insurance: _____ ID # _____

Are you allergic to any medications? YES NO If yes, list below:

1. _____ 2. _____

List all medications you are currently taking

Please circle to answer choice

Past Medical History – Do you have any history of:

Hypertension:	Yes No	Keloid scarring:	Yes No
Heart Disease:	Yes No	Problems with healing:	Yes No
Diabetes:	Yes No	Eczema:	Yes No
Asthma/COPD:	Yes No	Psoriasis:	Yes No
Arthritis:	Yes No	Atypical moles:	Yes No
Pacemaker:	Yes No	HIV positive:	Yes No
Artificial valves:	Yes No	Hepatitis C positive:	Yes No
Cancer:	Yes No	Problems with anesthesia:	Yes No

Patient name: _____

Skin Cancer History

Pre skin cancer: Yes No
Basal Cell Carcinoma: Yes No
Squamous Cell Carcinoma: Yes No
Malignant Melanoma: Yes No

Family History

Family hx of skin cancer: Yes No
Family hx of melanoma: Yes No
Family hx of other skin diseases: Yes No

Surgical History

Artificial hip joint: Yes No
Artificial joint: Yes No

Social History

Alcohol Consumption: Never Occasionally Frequently (every day)
Smoking Status: Current Everyday Some Days Former Smoker Never
Sunscreen use: Yes No At least 1 blistering sunburn: Yes No
Did you get your flu shot this year? Yes No
Did you get you pneumonia shot this year? Yes No
Any other information you would like us to know:
