MEDICAL INFORMATION

Date_____________

Patient Name___________________________________ Chart #__________________________

DESCRIBE CURRENT SKIN CONDITION____
____

PAST/FAMILY/SOCIAL HISTORY

1) **Have you had skin cancer**? NO _____ YES _____ WHERE/WHICH TYPE?______________________________________
2) **Do any family members have/had skin cancer**? NO____YES_____WHICHTYPE? __________________________________
3) Have you recently been hospitalized or spent time visiting in a hospital? NO____YES____EXPLAIN_________________
4) Do you wear sunscreen? NO_____YES_____
5) Do you spend much time with your hands in water? NO_____YES_____
6) Do any family members have the condition for which you are seeing us today? NO_____YES______WHO? _________
7) Do you or any family members have seasonal allergies or asthma? N_____YES_____RELATIONSHIP________________
8) Do you work outdoors, spend a significant amount of time in the sun or use a tanning bed? NO_____YES______
9) Do you drink alcohol? NO _____YES______ SOCIAL_______EXPLAIN____
10) Do you smoke? NO ______YES______ IF SO, HOW MUCH:____
11) Do you have advanced directive? NO_______ YES________

REVIEW OF SYSTEMS

(PLEASE CHECK IF YOU HAVE ANY OF THE FOLLOWING)

____ Heart Problems
____Pacemaker/Defibrillator
____Heart Valves/Stents
____High Blood Pressure
____High Cholesterol
____Easy Bleeding
____Lupus
____Glaucoma
____Thyroid Disease
____Kidney Disease
____Venereal Disease
____Arthritis
____Cold Sores
____Poor Healing
____Artificial Joints/Replacements-type and year________________________________
____Currently Pregnant
____Diabetes
____Anemia
____Seizures
____Depression
____Anxiety
____HIV/AIDS ____Asthma
____Breastfeeding
____H/O Drug or ETOH Dependency
____Hepatitis-type_____________
____Scar Easily
____Seasonal Allergies
____Emphysema

LIST OTHER CURRENT MEDICAL PROBLEMS: ____
____

MEDICATION

Have you taken any **ASPIRIN, PLAVIX, COUMADIN, PERSANTINE, HEPARIN, MOTRIN, ADVIL, FISH OIL** or other pain relievers or Arthritis medications in the last TWO weeks? NO_____YES______ Please List:
____

Do you require **premedication** before surgical procedures? NO_____YES______

MEDICATION ALLERGIES AND REACTION:____
____

CURRENT MEDICATIONS (include OTC and herbal):____
____
____

PHARMACY OF CHOICE: __________________________**PHONE #:**___________________**FAX#**________________
REFERRING DR.:_________________________________ **PHONE #:**____