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SOUTHERN DERMATOLOGY

SKIN CANCER CENTER
SKIN RENEWAL CENTER

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MEDICAL HISTORY FORM

Patient Name:____**DATE:** ____

Date of Birth:____Chart #: ____

Pharmacy:____Phone #:_________________________

Pharmacy Address:__________________________________Zip Code: _______________________

Primary Care Doctor Name: ____

Referring Physician Name:____

Emergency Contact and Ph#:____

Employer Name:___________________________________ Occupation: _____________________________

Medications: (Please Enter All Current Medications)

Medication Name	Strength (mg)	Route (oral, topical)	Dose (# of pills taken)	Frequency

Allergies: (Please Enter All Allergies)____

PAST MEDICAL HISTORY

(Please Select All That Apply)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplantation
- ☐ BPH (Benign Prostatic Hyperplasia)
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD (Emphysema)
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD (Acid Reflux)
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Other: ________________________
- ☐ None

PAST SURGICAL HISTORY

(Please Select All That Apply)

- ☐ Appendix Removed
- ☐ Bladder Removed
- ☐ Mastectomy (Right, Left, Both)
- ☐ Lumpectomy (Right, Left, Both)
- ☐ Breast Biopsy (Right, Left, Both)
- ☐ Breast Reduction
- ☐ Breast Implants
- ☐ Colon Cancer Resection
- ☐ Diverticulitis
- ☐ Inflammatory Bowel Disease
- ☐ Gallbladder Removed
- ☐ Coronary Artery Bypass
- ☐ PTCA
- ☐ Mechanical Valve Replacement
- ☐ Biological Valve Replacement
- ☐ Heart Transplant
- ☐ Joint Replacement, Knee (Right, Left, Both)
- ☐ Joint Replacement, Hip (Right, Left, Both)
- ☐ Kidney Biopsy
- ☐ Kidney Removed (Right, Left)
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Ovaries Removed: Endometriosis
- ☐ Ovaries Removed: Cyst
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Prostate Removed: Prostate Cancer
- ☐ Prostate Biopsy
- ☐ TURP
- ☐ Skin Biopsy
- ☐ Basal Cell Cancer Surgery
- ☐ Squamous Cell Carcinoma Surgery
- ☐ Melanoma Surgery
- ☐ Spleen Removed
- ☐ Testicles Removed (Right, Left, Both)
- ☐ Hysterectomy: Fibroids
- ☐ Hysterectomy: Uterine Cancer
- ☐ Other: ________________________
- ☐ None

SKIN DISEASE HISTORY

(Please Select All That Apply)

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Cold Sores/HSV
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ Other: ________________________
- ☐ None

Do you have a family history of Melanoma? ¨ Yes ¨ No

If yes, which relative(s)?

Any other family history:

SOCIAL HISTORY

(Please Select One in Each Section)

Smoking Status: ¨ Daily smoker ¨ Occasional smoker ¨ Former smoker ¨ Never smoked
Alcohol Use: ¨ Never ¨ Drink less than 1 per day ¨ Drink 1-2 per day ¨ Drink 3 or more per day

REVIEW OF SYSTEMS

(Have you had any of the following in the last 30 days?)

Condition	Yes	No
Problems with Bleeding	□ Yes	□ No
Problems with Healing	□ Yes	□ No
Problems with Scarring	□ Yes	□ No
Rash	□ Yes	□ No
Immunosuppression	□ Yes	□ No
Hay Fever	□ Yes	□ No
Chest Pain	□ Yes	□ No
Fever or Chills	□ Yes	□ No
Night Sweats	□ Yes	□ No
Unintentional Weight Loss	□ Yes	□ No
Thyroid Problems	□ Yes	□ No
Sore Throat	□ Yes	□ No
Blurry Vision	□ Yes	□ No
Abdominal Pain	□ Yes	□ No
Bloody Stool	□ Yes	□ No
Bloody Urine	□ Yes	□ No
Joint Aches	□ Yes	□ No
Muscle Weakness	□ Yes	□ No
Neck Stiffness	□ Yes	□ No
Headaches	□ Yes	□ No
Seizures	□ Yes	□ No
Cough	□ Yes	□ No
Shortness of Breath	□ Yes	□ No
Wheezing	□ Yes	□ No
Anxiety	□ Yes	□ No
Depression	□ Yes	□ No
Allergy to Adhesive	□ Yes	□ No
Allergy to Lidocaine	□ Yes	□ No
Allergy to Topical Antibiotic Ointments	□ Yes	□ No
Artificial Heart Valve	□ Yes	□ No
Artificial Joints within past 2 years	□ Yes	□ No
Blood Thinners	□ Yes	□ No
Defibrillator	□ Yes	□ No
MRSA	□ Yes	□ No
Pacemaker	□ Yes	□ No
Premedication prior to Procedures	□ Yes	□ No
Rapid Heart Beat with Epinephrine	□ Yes	□ No
Pregnancy or Planning a Pregnancy	□ Yes	□ No