DERMATOLOGY & SKIN CANCER CENTER, P.C.

MEDICAL INFORMATION SHEET

TODAY'S DATE: _____ **PATIENT NAME:** _____ **DOB:** _____

MEDICAL HISTORY: PLEASE CHECK ALL THAT MAY APPLY TO YOU

___ **NO** MEDICAL PROBLEMS
___ HEART ATTACK
___ CONGESTIVE HEART FAILURE
___ ANEURYSM (AORTIC)
___ ANGINA
___ AORTIC VALVE DYSFUNCTION
___ MITRAL VALVE DYSFUNCTION
___ CAROTID ARTERY DISEASE
___ CORONARY ARTERY DISEASE
___ HEART ARRHYTHMIA
___ PACEMAKER
___ HEART MURMUR
___ HIGH BLOOD PRESSURE
___ HIGH CHOLESTEROL
___ BLEEDING DISORDER
___ BLOOD CLOTTING DISORDER
___ PULMONARY EMBOLISM (BLOOD CLOT, LUNG)
___ DEEP VEIN EMBOLISM (BLOOD CLOT, LEG)
___ HYPOTHYROIDISM
___ HIV OR AIDS
___ LEUKEMIA OR LYMPHOMA
___ DIABETES, INSULIN
___ DIABETES, NON-INSULIN
___ ASTHMA
___ EMPHYSEMA OR COPD
___ PNEUMONIA
___ TUBERCULOSIS
___ PERIPHERAL VASCULAR DISEASE
___ HIATAL HERNIA/REFLUX DISEASE
___ PEPTIC ULCER DISEASE
___ DIVERTICULITIS
___ URINARY TRACT INFECTIONS
___ KIDNEY DISEASE
___ KIDNEY STONES
___ OSTEOPOROSIS
___ SEIZURE DISORDER
___ FIBROMYALGIA
___ GOUT
___ OSTEOARTHRITIS
___ RHEUMATOID DISEASE
___ STROKE OR MINISTROKE
___ MIGRAINE HEADACHES
___ LIVER DISEASE
___ PSORIASIS
___ POLIOMYELITIS
___ HISTORY OF MRSA (STAPH INFECTION)
___ ANXIETY DISORDER
___ DEPRESSION
___ DRUG ADDICTION
___ CLAUSTROPHOBIC (FEARFUL OF ENCLOSED SPACES)
___ PSYCHIATRIC DISORDER
___ GLAUCOMA
___ CANCER (NON SKIN CANCER):
TYPE: _____
_____
_____
___ HEPATITIS:
TYPE: _____

PAST SURGICAL HISTORY: PLEASE CHECK ANY THAT APPLY, INCLUDE EITHER THE **YEAR** IT WAS PERFORMED OR YOUR **AGE** AT THE TIME OF THE PROCEDURE *APPROXIMATELY*.

___ **NO** PREVIOUS SURGERY	_____**N/A**_____	___ VASCULAR SURGERY	_____
___ SPINE SURGERY	_____	___ BYPASS SURGERY	_____
___ APPENDECTOMY	_____	___ CARDIAC STENT	_____
___ C-SECTION	_____	___ VALVE REPLACEMENT	_____
___ CHOLECYSTECTOMY	_____	___ RADIATION THERAPY	_____
___ HERNIA REPAIR	_____	___**JOINT REPLACEMENT**	
___ HYSTERECTOMY	_____	TYPE: _____	_____
___ TONSILLECTOMY	_____	_____	_____
___ DEFIBRILLATOR	_____	___ **ORGAN TRANSPLANT**	
___ PACEMAKER	_____	TYPE: _____	_____
___ CAROTID SURGERY	_____	_____	_____

PLEASE LIST ANY ADDITIONAL MEDICAL HISTORY OR SURGICAL HISTORY:

_____

_____

DERMATOLOGICAL HISTORY: PLEASE CHECK OFF ANY THAT MAY APPLY TO YOU

___ ACTINIC KERATOSES	___ HERPES SIMPLEX	___ MELANOMA
___ ACNE	___ HERPES ZOSTER	___ PSORIASIS
___ ATYPICAL NEVI	___ KELOIDS	___ ROSACEA
___ BASAL CELL CARCINOMA	___ LIPOMA	___ SQUAMOUS CELL CARCINOMA
___ BIRTH MARK	___ LUPUS	___ STASIS DERMATITIS
___ CELLULITIS	___ LYME DISEASE	___ URTICARIA
___ ECZEMA/ATOPIC DERMATITIS	___ NEVI	___ VARICOSE VEINS

PLEASE LIST ANY ADDITIONAL DERMATOLOGICAL HISTORY:

_____

_____

SKIN TYPE AND SUN EXPOSURE HISTORY:

NATURAL HAIR COLOR: _____ BLONDE _____ RED _____ BROWN _____ BLACK

EYE COLOR: _____ BLUE _____GREEN _____ BROWN _____ HAZEL

HOW WOULD YOU BEST DESCRIBE YOUR SKIN?

____ ALWAYS BURNS, NEVER TANS _____SOMETIMES BURNS, ALWAYS TANS _____ NEVER BURNS, ALWAYS TANS, BROWN SKIN

_____ ALWAYS BURNS, SOMETIMES TANS _____ NEVER BURNS, ALWAYS TANS _____ NEVER BURNS, BLACK SKIN

NUMBER OF SUNBURNS (OVER LIFETIME): _____ NEVER _____ SINGLE, SEVERE BURN _____ SUNBURN GREATER THAN 5

SUN EXPOSURE (OVER LIFETIME): _____ MINIMAL _____ MODERATE _____ EXTENSIVE _____ OCCUPATIONAL _____ RECREATIONAL

DO YOU USE SUNSCREEN? _____ **IF YES, SPF** _____ **DO YOU USE TANNING BEDS**? _____ IF YES, FREQUENCY _____

MEDICATIONS: PLEASE LIST ALL MEDICATIONS OR DRUGS INCLUDING BIRTH CONTROL PILLS, OVER-THE-COUNTER MEDICATIONS AND/OR HERBAL SUPPLEMENTS YOU ARE CURRENTLY TAKING AND THE DOSAGE OF EACH MEDICATION.

MEDICATION NAME	AMOUNT/DOSE	MEDICATION NAME	AMOUNT/DOSE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PHARMACY NAME: _____

LOCATION: _____ **PHONE #:** _____

DO YOU NEED TO TAKE ANTIBIOTICS PRIOR TO PROCEDURES? _____ YES _____ NO

IF YES, FOR WHAT REASON? _____

IF YES, WHAT ANTIBIOTIC DO YOU TAKE? _____

ALLERGIES: PLEASE LIST ALL ALLERGIES TO ANY OF THE FOLLOWING: MEDICATIONS, METALS, DYES, LATEX, FOODS, BANDAGES, ADHESIVE TAPES. IF YOU DO NOT HAVE ANY ALLERGIES, PLEASE WRITE **NONE** ON THE FIRST LINE OF THE LIST.

ALLERGY	ONSET	REACTION
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY HISTORY: PLEASE CHECK IF ANY APPLY TO YOUR IMMEDIATE FAMILY. PLEASE CIRCLE FOR (M)OTHER, (F)ATHER, (S)ISTER, (B)ROTHER WHERE APPLICABLE.

___ NO MEDICAL CONDITION

___ ABNORMAL MOLES M F S B
___ AUTOIMMUNE DISEASE M F S B
___ ASTHMA M F S B
___ BASAL CELL CARCINOMA M F S B
___ CANCER (NON SKIN CANCER) M F S B
TYPE: _____
___ DIABETES, INSULIN M F S B
___ DIABETES, NON-INSULIN M F S B
___ ECZEMA M F S B
___ HEART DISEASE M F S B
___ HIGH BLOOD PRESSURE M F S B
___ KELOIDS M F S B
___ MALIGNANT MELANOMA M F S B
___ PSORIASIS M F S B
___ RHEUMATOID ARTHRITIS M F S B
___ ROSACEA M F S B
___ SQUAMOUS CELL CARCINOMA M F S B
___ STROKE M F S B
___ OTHER: M F S B
_____
_____

SOCIAL HISTORY:

MARITAL STATUS: ___ MARRIED ___SINGLE ___DIVORCED ___SEPARATED ___WIDOWED ___LIVING WITH SIGNIFICANT OTHER

NAME OF SPOUSE/SIGNIFICANT OTHER: _____ **NUMBER OF CHILDREN**: _____

ARE YOU PREGNANT? _____ **ARE YOU NURSING?** _____

DO YOU SMOKE? _____ **IF YES, HOW MANY PACKS A DAY**?: _____ **IF YES, AGE STARTED**: _____

IF YOU WERE A FORMER SMOKER, IN WHAT YEAR DID YOU QUIT? : _____

DO YOU USE CHEWING TOBACCO?: _____ **IF YES, HOW MANY TINS/POUCHES A DAY**?: _____ **IF YES, AGE STARTED**: _____

DO YOU USE ALCOHOL? _____ **IF YES, HOW OFTEN**?: _____RARELY _____ MODERATE _____ HEAVY

WHAT DO YOU TEND TO DRINK? _____BEER _____WINE _____ LIQUOR

DO YOU USE CAFFEINE? _____ **IF YES, HOW OFTEN?**: _____RARELY _____MODERATE _____ HEAVY

WHAT DO YOU TEND TO CONSUME? _____CHOCOLATE _____SODA _____COFFEE _____ TEA _____ENERGY DRINKS _____TABLETS

DO YOU EXERCISE? _____ **IF YES, HOW OFTEN**? _____

DO YOU USE ASSISTANCE DEVICES? _____ **IF YES, WHICH DEVICE DO YOU USE**? _____WALKER _____CANE _____ WHEELCHAIR

EDUCATION: HIGHEST COMPLETED LEVEL: ___ HIGH SCHOOL ___ 2 YEAR COLLEGE ___4 YEAR COLLEGE ___ POST GRADUATE

DEGREE(S) OBTAINED: _____

OCCUPATIONAL HISTORY: EMPLOYER (IF APPLICABLE) : _____

IF YOU ARE NOT WORKING, WHAT WAS YOUR PRIMARY OCCUPATION?: _____

DURING CURRENT/PREVIOUS OCCUPATIONS WERE YOU EXPOSED TO (CIRCLE ANY THAT APPLY) :

WELL WATER ARSENIC PESTICIDES AGENT ORANGE RADIATION OTHER: _____

THIS SIGNATURE AUTHORIZES THAT YOU HAVE ANSWERED THE ABOVE QUESTIONS TO THE BEST OF YOUR KNOWLEDGE AND, IF AT ANY POINT THIS INFORMATION SHOULD CHANGE, YOU WILL CONTACT OUR OFFICE TO UPDATE OUR RECORDS.

_____ _____

SIGNATURE OF PATIENT/GUARDIAN **DATE**