SKIN SURGERY CENTER OF VIRGINIA

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Skin Surgery/Exam - Medical History Form

Patient Name: _____ Date: _____

Sex: [ ] Male [ ] Female Date of Birth: _____ Accompanied by: _____

Consult requested by: [ ] Dr. _____ Referred by: [ ] Self [ ] Friend _____

Reason for today's visit: [ ] Mohs [ ] Skin Cancer Monitoring [ ] Suspicious Lesion [ ] Other _____

History of today's problem(s) only: **[ ] No problem today** **[ ] Problems today are listed below**

	Problem # 1	**Problem # 2**	**Problem # 3**
Skin areas involved:			
How long present?			
Previously biopsied?			
Treatment? *(When/Type)*:			

Check all that apply to today's problem(s): [ ] Not Applicable

Quality *(a change in)*	**Modifying Factors** *(a history of)*	**Associated Symptoms**	**Severity**
☐ Size ☐ Elevation	☐ X-Ray Treatments *(not routine or dental)* ☐ UV Light Treatments	☐ Bleeding ☐ Tingling	☐ No Symptoms
☐ Color ☐ Hardness	☐ Immunosuppression ☐ Tanning Bed Use	☐ Ulceration ☐ Infection	☐ Occasional Symptoms
☐ None	☐ None	☐ Itching Pain ☐	☐ Constant Symptoms
☐ Other:_____		☐ None ☐	

System Review **(***Check all that apply and add any other important problems)*

[ ] None [ ] Bleeding Problems [ ] Easy Bruising [ ] Enlarged Lymph Nodes [ ] New or Changing Mole/Lesion

[ ] History of Today's Problems *(refer to above)* [ ] Other _____

Past Medical History *(Check all that apply and add any other important problems)*

[ ] None [ ] High Blood Pressure [ ] Diabetes [ ] Pregnant [ ] Breastfeeding

[ ] Heart Disease [ ] HIV/AIDS [ ] Depression [ ] Anxiety Attacks [ ] Heart Valve Dysfunction

[ ] Hepatitis B [ ] Stroke [ ] Faints Easily [ ] Artificial Heart Valve [ ] Tuberculosis

[ ] Hepatitis C [ ] Renal Failure [ ] Pacemaker [ ] Hepatitis/Cirrhosis [ ] Leukemia/Lymphoma

[ ] Abnormal Platelet [ ] Artificial Joint [ ] Blood Transfusions [ ] Organ Transplant [ ] Myelodysplastic Synd.

[ ] Abnormal Scarring/Keloids [ ] Needs Antibiotics prior to Dental Procedure [ ] Implantable Neurological Device

Previous Skin Cancer: [ ] No [ ] Yes, please list location, date and treatments: _____

_____

Other Major Illnesses, Surgeries, Hospitalizations [ ] No [ ] Yes, please list: _____

_____

Family history of skin cancer? [ ] None [ ] Basal Cell [ ] Squamous Cell [ ] Melanoma

What is your occupation? _____ Is English your main language? [ ] Yes [ ] No _____

Do you have any problems with mobility? [ ] No [ ] Yes _____

Do you have religious, cultural, spiritual practices that might affect how we treat you? [ ] No [ ] Yes _____

Do you have any problems with your vision or hearing that might affect how we teach you? [ ] No [ ] Yes _____

Patient Medication Form

Date: _____

Name: _____ Date of Birth: _____

****Required Pharmacy Information:**

Name: _____ Phone: _____

Are you **allergic** to any medications?

[ ] No, I have no known allergies to medication

[ ] Yes, I have an allergy to the medication(s) listed below:

Medication: _____ Medication: _____

Medication: _____ Medication: _____

Do you take any of the following **blood thinners?** *(Please mark all that apply)*

[ ] Aspirin [ ] Plavix (Clopidogrel) [ ] Coumadin (Warfarin) [ ] Pradaxa (Dabigatran)

[ ] Aggrenox (Dipyridamole) [ ] Lovenox (Enoxaparin) [ ] Xarelto (Riveroxaban) [ ] Ticlid (Ticlopidine)

[ ] Effient (Prasurgrel) [ ] Fragmin (Dalteparin)

Do you have a **pacemaker?** [ ] Yes [ ] No Do you have a **defibrillator?** [ ] Yes [ ] No

Do you smoke? [ ] No [ ] Former [ ] Yes, packs per day _____

Please list all medications that you are currently taking:

Prescribed Medication	**Dosage**	**Over the Counter Medication** *include vitamins and supplements*	**Dosage**