SKIN SURGERY CENTER
OF VIRGINIA

Christine S. Rausch, M.D., FACMS • Skin Cancer Specialist • Mohs Micrographic Surgeon
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Plastic Surgery – 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: [ ]

_____

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 [ ] Asthma [ ] Blood Transfusions

[ ] Problems with Anesthesia [ ] Thyroid Disorder [ ] Glaucoma [ ] Hepatitis C [ ] Hepatitis/Cirrhosis

[ ] Depression/Anxiety [ ] Eye Surgery (Lasik) [ ] Heart Disease [ ] Stroke [ ] Heart Valve Dysfunction

[ ] Artificial Heart Valve [ ] Pacemaker [ ] HIV/AIDS [ ] Artificial Joint [ ] Radiation Therapy

[ ] Autoimmune Disease [ ] Abnormal Platelet [ ] Renal Failure [ ] Organ Transplant

[ ] Abnormal Scarring/Keloids [ ] Spontaneous Abortions or Miscarriages [ ] Blood Clots or Pulmonary Embolism

[ ] Needs Antibiotics prior to Dental Procedure [ ] Implantable Neurological Device

[ ] Other: _____

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

_____

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

_____

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

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

[ ] BRCA Positive (breast cancer) [ ] Breast Cancer [ ] Heart Attack (MI) [ ] Stroke

[ ] Malignant Hypertension [ ] Blood Clots or Pulmonary Embolism [ ] Problems with Anesthesia

[ ] Other: _____

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 herbal medications? [ ] No [ ] Yes Type: _____

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

Do you use alcohol? [ ] No [ ] Yes, drinks per day _____

Please list all medications that you are currently taking:

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