

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 Rash Acne Hair Loss
 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

Associated Symptoms
<input type="checkbox"/> Bleeding <input type="checkbox"/> Tingling <input type="checkbox"/> Itching <input type="checkbox"/> Scaly <input type="checkbox"/> Pain/sore/tender <input type="checkbox"/> Burning <input type="checkbox"/> Spreading <input type="checkbox"/> Redness <input type="checkbox"/> Other <input type="checkbox"/> None

Height _____ Weight _____

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 RA/Lupus Tuberculosis
 Hepatitis C Renal Failure Pacemaker Hepatitis/Cirrhosis Leukemia/Lymphoma
 Platelet dysfunction Artificial Joint Blood Transfusions Organ Transplant Myelodysplastic Synd.
 Cancer Radiation Therapy Dementia High Cholesterol History of MRSA/Staph
 Abnormal Scarring/Keloids Needs Antibiotics prior to Dental Procedure Implantable Neurological Device

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

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 treat you? [] No [] Yes _____

Smoking/Tobacco Status (this includes all forms of tobacco products)

- Current- Year started _____
- Former- Year started _____ Year stopped _____
- Type of tobacco product _____
- Never

Alcohol Status

How many times in the last year have you had 5 or more drinks in one sitting? _____

Flu Vaccine

- Previously immunized- date (include month and year) _____
- Not immunized

Pneumonia Vaccine

- Previously immunized- date (include month and year) _____
- Not immunized

Patient Medication Information

Date: _____ Name: _____ Date of Birth: _____

****Required Pharmacy Information:**

Pharmacy Name: _____ Pharmacy 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: _____

Please list all medications that you are currently taking:

Prescribed and Over the counter medications

Please include dosage and how often you take them

Updated- 5/8/2019-jle, 2/2020-jle
SSCV/front desk manual/forms/mohs mailer forms/updated mailer forms