

# THE CENTER FOR SKIN SURGERY

## Patient Medical History

**\*\*DO NOT MAIL IN\*\***

**PLEASE BRING THIS FORM WITH YOU TO YOUR APPOINTMENT**

Name: \_\_\_\_\_ Male  Female

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

PRIMARY INSURANCE (Plan Name) \_\_\_\_\_

Policy Holder (Name) \_\_\_\_\_

Policy Holder's Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

SECONDARY INSURANCE (Plan Name) \_\_\_\_\_

Policy Holder (Name) \_\_\_\_\_

Policy Holder's Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

Do you live alone? Yes  No

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_

Mailing Address (if different): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Alternate Address (seasonal): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**In Case of Emergency Contact:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Who referred you to our practice?** \_\_\_\_\_

	<b>Referring Physician</b>	<b>Primary Care Physician</b>
Name		
Street Address		
City, State, Zip		
Phone #		

Please list any past illness or surgery for which you were hospitalized. List with approximate date, place and type.

Operation/Illness	Hospital	City	State	Date

List and describe any **ALLERGIES** to medications or other substances.

---

---

List any current medications. Please include all prescriptions and non-prescription drugs.

Medication	How Often Taken

Are you currently taking ASPIRIN? \_\_\_\_\_ Coumadin? \_\_\_\_\_ Plavix? \_\_\_\_\_  
Are you currently taking any cortisone (steroid) drug? \_\_\_\_\_

Do you use tobacco? \_\_\_\_\_  
If yes, amount per day \_\_\_\_\_  
Number of years \_\_\_\_\_

If No, did you use tobacco in the past? \_\_\_\_\_  
Date stopped \_\_\_\_\_

How much alcohol do you consume each week? \_\_\_\_\_

Have you ever had a blood transfusion? \_\_\_\_\_ If yes, when? \_\_\_\_\_

Weight \_\_\_\_\_ Any recent weight loss? \_\_\_\_\_ If yes, how much? \_\_\_\_\_

---

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Do you have a history of any of the following symptoms or disorders?**

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Recurrent fevers | <input type="checkbox"/> Lung Problems (asthma/emphysema)  | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Glaucoma/eye disease |
| <input type="checkbox"/> Thyroid disease  | <input type="checkbox"/> Mouth ulcers, infections, growths | <input type="checkbox"/> Pneumonia          | <input type="checkbox"/> Bleeding tendency    |
| <input type="checkbox"/> Sinus problems   | <input type="checkbox"/> Stomach ulcers                    | <input type="checkbox"/> Anemia             | <input type="checkbox"/> Urinary Problems     |
| <input type="checkbox"/> Organ transplant | <input type="checkbox"/> Difficulty hearing/hearing aids   | <input type="checkbox"/> Cancer             | <input type="checkbox"/> Kidney Disease       |
| <input type="checkbox"/> Heart disease    | <input type="checkbox"/> Hepatitis/liver problems          | <input type="checkbox"/> HIV/AIDS           | <input type="checkbox"/> Enlarged lymph nodes |
| <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Anxiety, depression               | <input type="checkbox"/> Stroke             | <input type="checkbox"/> Rheumatic fever      |
| <input type="checkbox"/> Seizures         | <input type="checkbox"/> High Blood Pressure               | <input type="checkbox"/> Emphysema          |   |
| <input type="checkbox"/> Other:           | <input type="checkbox"/> Osteoporosis (thin bones)         | <input type="checkbox"/> Immune Suppression |   |

Have you ever had any of the following skin diseases?

- |  |   |                                 |
|--|---|---------------------------------|
| <input type="checkbox"/> Basal cell cancer | <input type="checkbox"/> Squamous cell cancer   | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Psoriasis         | <input type="checkbox"/> Keloids/elevated scars | <input type="checkbox"/> Acne   |
| <input type="checkbox"/> Melanoma          | <input type="checkbox"/> Fungal infections      | <input type="checkbox"/> Warts  |
| <input type="checkbox"/> Other:            | <input type="checkbox"/> Hair Loss              |                                 |

What is the problem for which you are being seen today? \_\_\_\_\_

How long have you had your current problem? \_\_\_\_\_

Where on your body is your current problem? \_\_\_\_\_

Has your current problem ever been treated? \_\_\_\_\_ If yes, explain \_\_\_\_\_

How does your current problem bother you (i.e. itchy, painful, bleeds, doesn't heal)? \_\_\_\_\_

**Do you have a family history of any skin disease, cancer or significant medical disease (e.g. diabetes, thyroid disease, arthritis)?**

Relative:	Disease:
_____	_____
_____	_____
_____	_____

Do you have a pace maker? \_\_\_\_\_ defibrillator? \_\_\_\_\_ artificial heart valve? \_\_\_\_\_

Are you pregnant or breast feeding? \_\_\_\_\_