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: _____

Local Pharmacy _____Phone:_____

In Case of Emergency Contact: _____ Phone: _____

Who referred you to our practice?_____

	Referring Physician	**Primary Care Physician**
Name		
Street Address		
City, State, Zip		
Phone #		

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? _____ How much alcohol do you consume
If yes, amount per day _____ each week? _____
Number of years _____

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

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)? _____

Patient Signature: _____ Date:_____

Physician Signature: _____ Date: _____

FORM REVIEWED/UPDATED	FORM REVIEWED/UPDATED
Patient Signature _____ Date: _____	Patient Signature _____ Date:_____
Physician Signature _____ Date: _____	Physician Signature _____ Date:_____

Do you currently have any of the following symptoms? [REVIEW OF SYSTEMS]

□ Weight loss	□ Chest pain	□ Diarrhea	□ Changes in vision
□ Fever	□ Shortness of breath	□ Nausea/vomitting	□ Swollen lymph nodes
□ Chills	□ Abdominal pan	□ Lumps/bumps	□ Bleeding tendencies
□ Night Sweats	□ Urinary problems (difficulty urinating or blood in your urine)	□ Headache	□ Depression/ anxiety
□ Cough	□ Weakness	□ Arthritis	□ Other:
			□ **N/A**

Have you been diagnosed with any of the following illnesses or medical conditions? [PMH]

□ Heart Disease	□ Diabetes	□ Urinary problems	□ HIV/Aids
□ Lung Problems	□ Thyroid Disease	□ Mental Illness	□ Hepatitis
□ Hypertension	□ GI Problems	□ Stroke	□ Other: _____
			□ **N/A**

Do you have a previous history of skin cancer? Yes ____ No ____

If yes, what type:

□ Basal cell cancer	□ Malignant Melanoma in situ
□ Squamous Cell Carcinoma	□ Other:
□ Malignant Melanoma	□

Do you have a family history of any skin cancer? _____
If yes, please explain:

Relative	Type of Cancer
_____	_____
_____	_____
_____	_____

Do you have a pace maker? ____ defibrillator? _____ artificial heart valve? ____ Are you pregnant or breast feeding? _____

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