

Patient Name _____ Date of Birth _____

LIST YOUR PAST SURGERIES AND APPROXIMATE TIME/AGE

PLEASE ANSWER THE FOLLOWING:

- 1. Currently Married?.....Y/N Single?.....Y/N Divorced?.....Y/N Children?.....Y/N How many?
2. Do you drink alcohol?.....Y/N How much/week?
3. Do you smoke/chew tobacco?.....Y/N How much?
4. Do you use recreational drugs?.....Y/N What drug(s)?
5. Do you bleed easily/aspirin?.....Y/N
6. Any artificial joints?.....Y/N Where?
7. Women:
Are you pregnant?.....Y/N Breast feeding?.....Y/N
Due Date
Are you on The Pill/Patch.....Y/N Depoprovera shots?.....Y/N
Estrogen?.....Y/N
Progesterone?.....Y/N IUD?.....Y/N: Implants?

FAMILY HISTORY OF MEDICAL DISEASES:

- Cancer.....Y/N Arthritis.....Y/N
High blood pressure.....Y/N Diabetes.....Y/N
Heart disease.....Y/N Allergy/hayfever/sinus/asthma..Y/N
Stroke.....Y/N Cystic ovaries.....Y/N
Blood Clots.....Y/N Other
Family history of NON cancerous skin diseases.....Y/N

SKIN HISTORY

- 1. Where did you grow up? Were you a lifeguard? Y/N
2. Did you get any blistering sunburns before age 21?...Y/N How many?
3. Have you used tanning bed in the past? Y/N Currently? Y/N How Often?
4. ANYONE IN YOUR FAMILY HAVE SKIN CANCER?.....Y/N
Basal cell?..... Y/N
Squamous cell?..... Y/N
Melanoma?..... Y/N
Pre cancer?.....Y/N
4. Have YOU had skin cancers?
Basal cell?.....Y/N
Squamous cell?.....Y/N
Melanoma?.....Y/N
Pre cancer?..... Y/N
5. Do you have a history of skin disease?.....Y/N: PSORIASIS / ECZEMA / VITILIGO / ACNE
6. Any other diseases or conditions we should know about?.....Y/N
If so, please describe.

- 7. When you are exposed to the Sun do you: TAN / TAN and BURN / BURN
8. Do you use sunscreen daily?.....Y/N
9. Any surgery done in the past 6 months?.....Y/N
If so, what kind of surgery and when
10. What is your occupation?
11. What are your hobbies?

Completed by: Patient Other relationship Medical assistant
Reviewed by Date

Dr. Notes:
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