

**(\*\*PLEASE COMPLETE THIS FORM AND HAND IT TO A NURSE WHEN THEY BRING YOU BACK INTO A ROOM\*\*)**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

**Past Medical History: (please circle all that apply)**

- |   |  |   |
|---|--|---|
| <ul style="list-style-type: none"> <li>• None</li> <li>• Anxiety disorder</li> <li>• Arthritis</li> <li>• Asthma</li> <li>• Atrial Fibrillation</li> <li>• Benign Prostatic Hyperplasia</li> <li>• Cerebrovascular accident</li> <li>• Chronic obstructive lung disease</li> <li>• Coronary arteriosclerosis</li> <li>• Depression</li> <li>• Diabetes</li> </ul> | <ul style="list-style-type: none"> <li>• Disease cause by 2019-nCoV</li> <li>• High blood pressure</li> <li>• End-stage renal disease</li> <li>• Epilepsy</li> <li>• Acid Reflux</li> <li>• Hearing loss</li> <li>• HIV</li> <li>• High Cholesterol</li> <li>• Hyperthyroidism</li> <li>• Hypothyroidism</li> <li>• Inflammatory disease of liver</li> <li>• Leukemia</li> <li>• Malignant lymphoma</li> </ul> | <ul style="list-style-type: none"> <li>• Malignant tumour of lung</li> <li>• Malignant tumour of breasts</li> <li>• Malignant tumour of colon</li> <li>• Malignant tumour prostate</li> <li>• Radiation therapy treatment management</li> <li>• Transplantation of bone marrow</li> <li>• Other: _____<br/>_____</li> </ul> |
|---|--|---|

**Past Surgical History: (please circle all that apply)**

- |  |   |   |
|--|---|---|
| <ul style="list-style-type: none"> <li>• None</li> <li>• Abdominoperineal resection</li> <li>• Biopsy of breast</li> <li>• Biopsy of prostate</li> <li>• Coronary artery bypass graft</li> <li>• Entire transplanted kidney</li> <li>• Excision of basal cell carcinoma</li> <li>• Excision of melanoma</li> <li>• Excision of squamous cell carcinoma</li> <li>• colostomy</li> <li>• tubal ligation</li> </ul> | <ul style="list-style-type: none"> <li>• appendectomy</li> <li>• cholecystectomy</li> <li>• colostomy</li> <li>• PTCA</li> <li>• cystectomy</li> <li>• Hysterectomy</li> <li>• Kidney biopsy</li> <li>• Lumpectomy of breast, Left/ Right/ Bilateral</li> <li>• Mastectomy of left breast/Left/Right</li> <li>• Mechanical heart valve replacement</li> <li>• Oophorectomy</li> <li>• Pancreatectomy</li> <li>• Kidney stone removal</li> </ul> | <ul style="list-style-type: none"> <li>• Prostatectomy</li> <li>• Splenectomy</li> <li>• Surgical biopsy of skin</li> <li>• Total nephrectomy</li> <li>• Total orchiectomy</li> <li>• Total replacement of left hip joint/Right Hip</li> <li>• Total replacement of left knee joint/right knee</li> <li>• Transplantation of heart</li> <li>• Transplantation of liver</li> <li>• Other: _____<br/>_____</li> </ul> |
|--|---|---|

**Skin Disease History: (please circle all that apply)**

- |                                |                            |                |
|--------------------------------|----------------------------|----------------|
| • None                         | • H/O: asthma              | • Lupus        |
| • Acne                         | • H/O: hay fever           | • Shingles     |
| • Actinic Keratosis            | • Malignant melanoma       | • Cold Sores   |
| • Basal cell carcinoma of skin | • Pruritus of scalp        | • Vitiligo     |
| • Atopic dermatitis            | • Psoriasis                | • Other: _____ |
| • poison ivy                   | • Squamous cell carcinoma  | _____          |
| • Dysplastic nevus             | • Sunburn of second degree | _____          |
| • Eczema                       |                            | _____          |

**Skin Protection:**

Do you wear sunscreen? \_\_\_\_Yes \_\_\_\_No  
 If yes, what SPF? \_\_\_\_\_  
 Do you tan in a tanning salon? \_\_\_\_Yes \_\_\_\_No

**Family History of Melanoma:**

Do you have a family history of melanoma? \_\_\_\_Yes \_\_\_\_No  
 If yes, which relative(s)? \_\_\_\_\_

**Medications: (please enter all current medications & dosage)**

Medication Name and Dose	Frequency

Medication Allergies: \_\_\_\_\_  
\_\_\_\_\_

**Social History: (Please circle all that apply)**

**Cigarette Smoking:**

- Current everyday smoker
- Current some day smoker (tobacco)
- Current some day smoker (cigarette)
- Former smoker
- Never smoker
- Cigar Smoker
- Heavy tobacco smoker
- Light tobacco smoker
- NONE

**Alcohol Use:**

- less than 1 drink per day
- 1-2 drinks per day
- 3 or more drinks per day
- NONE

If over 65, do you have a medical proxy in the event that you cannot make your own medical decisions?

\_\_\_\_\_ Yes                      \_\_\_\_\_ No

If yes, what is their name and phone number? \_\_\_\_\_

Do you have a living will? \_\_\_\_\_

Do you have a Do Not Resuscitate or a Do Not Intubate? \_\_\_\_\_

**Family History: Signification disease & illness, skin or otherwise. Only first degree biological relatives-  
Mother, Father, Brother, Sister, Children**

Condition	Relative

**Review of Systems: Are you currently experiencing any of the following? (Please check “YES or “NO”)**

Symptom	Yes	No	Symptom	Yes	No
Abdominal Pain			Loss of smell or taste		
Muscle Weakness			Depression		
Anxiety			Seizures		
Neck Stiffness			Fever or Chills		
Bloody Stool			Shortness of Breath		
Bloody Urine			Hay Fever		
Problems with Bleeding			Thyroid Problems		
Blurred Vision			Headaches		
Problems with Healing			Unintentional Weight Loss		
Chest Pain			Immunosuppression		
Joint Aches			Wheezing		
Scarring (hypertrophic/keloid)			Other		

**Alerts: (please circle all that apply)**

- Blood Thinners
- Pacemaker
- Defibrillator
- Hepatitis B/C
- History of Melanoma
- HIV/AIDS
- Lactating or Breastfeeding
- Preoperative antibiotics
- Allergy to lidocaine
- EPI sensitive
- Pregnancy or planning pregnancy
- Latex Allergy
- Adhesive Allergy
- Joint replacements in last 6 months
- Vasovagal