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SKIN SURGERY CENTER
SKIN CANCER SPECIALISTS

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HEALTH HISTORY FORM

HEALTH HISTORY

Name of Patient (Last, First, M.I.)	Age of Patient	❑ Male ❑ Female	Date of Birth
Name of Dermatologist		Phone number ( )	
Name and Address of Primary Care Physician		Phone number ( )	
Skin areas involved	Any previous treatment to this area? ☐ Yes ☐ No	Type of treatment done	

CHECK ALL THAT APPLY TO TODAY'S PROBLEM

QUALITY
A change in
- ❑ size
- ❑ color
- ❑ elevation
- ❑ hardness
- ❑ other_____
- ❑ none

MODIFYING FACTORS
A history of
- ❑ X-ray treatments (Not routine dental or chest x-rays)
- ❑ UV light treatments
- ❑ Arsenic exp./treatments
- ❑ chronic scar
- ❑ immune-suppression or transplant
- ❑ none

ASSOCIATED SYMPTOMS
- ❑ bleeding
- ❑ tingling
- ❑ pain
- ❑ ulceration
- ❑ infection
- ❑ occasional symptoms
- ❑ constant symptoms
- ❑ other _____
- ❑itching
- ❑ no symptoms

SYSTEM REVIEW – Check all that apply regarding your health and add any other important problems.

List (or attach)all medications and their dose you are currently taking:	Pharmacy Name and Phone number: ( )
Do you have any allergies to medications? If so, please list.	Please list any major illnesses or hospitalizations.
HEIGHT _____ **WEIGHT** _____	**ADVANCE DIRECTIVE (aka living will)** ❑ No ❑ Yes, Please provide us a copy **(See Patient's Rights)**

SKIN
- ❑ normal
- ❑ excessive sunburn
- ❑ poor healing
- ❑ other skin disorders _____

NEUROLOGICAL
- ❑ normal
- ❑ stroke
- ❑ seizures
- ❑ dementia
- ❑ other _____

CARDIOVASCULAR
- ❑ normal
- ❑ angina
- ❑ **artificial heart valve**
- ❑ mitral valve prolapse
- ❑ **pacemaker / defibrillator**
- ❑ hypertension
- ❑ heart attack (when?): _____/_____
- ❑ irregular heart beat
- ❑ other _____

RESPIRATORY
- ❑ normal
- ❑ asthma
- ❑ emphysema
- ❑ other _____

EYE
- ❑ normal
- ❑ macular degeneration
- ❑ dry eye or blepharitis
- ❑ other _____

MUSCULOSKELETAL
- ❑ normal
- ❑ arthritis
- ❑ rheumatoid arthritis
- ❑ psoriatic arthritis
- ❑ **artificial joint (when?)** _____/_____
- ❑ metal rods or pins
- ❑ other _____

HEMATOLOGIC/LYMPHATIC
- ❑ normal
- ❑ anemia
- ❑ bleeding problems
- ❑ enlarged lymph nodes
- ❑ other _____

PSYCHIATRIC
- ❑ normal
- ❑ depression
- ❑ anxiety attacks
- ❑ other _____

INFECTIONS/ALLERGY
- ❑ none
- ❑ hepatitis B___C___
- ❑ HIV/AIDS
- ❑ tuberculosis (T.B.)
- ❑ rashes
- ❑ hives
- ❑ other _____

ENDOCRINE
- ❑ normal
- ❑ diabetes
- ❑ thyroid
- ❑ other _____

EARS/NOSE/MOUTH/THROAT
- ❑ normal
- ❑ hearing aid
- ❑ plastic surgery
- ❑ other _____

GASTROINTESTINAL
- ❑ normal
- ❑ stomach ulcer
- ❑ colitis
- ❑ other _____

GENITDURINARY
- ❑ normal
- ❑ kidney disease
- ❑ dialysis
- ❑ other _____

SUN / UV EXPOSURE	SMOKER
❑ excessive sun exposure ❑ history of tanning bed use (greater than 50 times) ❑ moderate ❑ current tanning bed use ❑ regular sunscreen use	❑ No ❑ Yes ❑ Former ❑ If Yes, packs per day _____
ALCOHOL ❑ Denies use ❑ Use socially ❑ Use daily ❑ Addiction issues	ILLEGAL DRUGS ❑ Denies use ❑ Yes, describe

PAST HISTORY Previous Skin Cancer ❑ Yes ❑ No If Yes, location Type of skin cancer ❑ Melanoma ❑ Basal Cell ❑ Squamous Cell

FAMILY HISTORY Skin Cancer ❑ None ❑ Melanoma ❑ Basal Cell ❑ Squamous Cell

SOCIAL HISTORY Retired ❑ Yes ❑ No
Occupation or Former Occupation Where did you grow up? (City/State/Country)

DATE COMPLETED _____