Patient ____ DOB ______________ Age________ Today's Date____________

Primary Care Physician: ____

Please check yes or no of the appropriate box of medical conditions you had or currently are experiencing (attach sheet if necessary):

	YES	NO		YES	NO
History of Skin Cancer?	▫	▫	Cosmetic Surgery?	▫	▫
History of transplanted organs?	▫	▫	Ears/Nose/Throat/Mouth?	▫	▫
Defibrillator?	▫	▫	Lungs	▫	▫
Pacemaker?	▫	▫	Stomach/Bowel	▫	▫
Do you need antibiotic prior to			Kidneys	▫	▫
dental cleanings?	▫	▫	Blood/Bleeding Disorders	▫	▫
Artificial Joints?	▫	▫	Hypertension	▫	▫
Artificial Heart Valve?	▫	▫	Irregular Heartbeat	▫	▫
Do you have any implanted ports			History of Heart Attack	▫	▫
or devices currently?	▫	▫	History of Stroke	▫	▫
History of Radiation for acne?	▫	▫	HIV/AIDS	▫	▫
Latex Allergy?	▫	▫	Hepatitis	▫	▫
Diabetes?	▫	▫	Psychological Disorders	▫	▫
Thyroid?	▫	▫	Headaches/Seizures	▫	▫

If you answered yes to History of transplanted organs, which ones? ____

If you answered yes to needing antibiotics prior to dental cleanings, why? ____

Please list any skin cancers and location(s): ____

Please list any other diseases or conditions: ____

List <u>all</u> medications you are currently taking, including over the counter medications, vitamins, and natural or holistic remedies. Include Dose and how often you take it.

_________________________________ _________________________________ _________________________________
_________________________________ _________________________________ _________________________________
_________________________________ _________________________________ _________________________________

Pharmacy Name_________________ **Pharmacy Phone #:**______________ **Cross streets:**______________________

Please list all Allergies to Medicines: (if not applicable please write N/A)

Medication: ______________________________ Reaction: ______________________________
______________________________ ______________________________
______________________________ ______________________________

Family History: (if not applicable please write N/A)

▫ Melanoma: who? ____________________________________ ▫ Basal cell skin cancer: who? _______________________

▫ Squamous cell skin cancer: who? ______________________ ▫ Unknown – Adopted: __________________________

Social History: Occupation: ________________________

Do you smoke? ▫ No ▫ Former ▫ Yes: How many packs per day? ______

Do you drink? ▫ No ▫ Former ▫ Yes: How many drinks per day? ______

Major surgeries by date in the last 5 years: ____

Hospitalizations in the last 5 years: ____

Women ONLY: Are you pregnant? ▫ Yes ▫ No Trying to get pregnant? ▫ Yes ▫ No Breast feeding? ▫ Yes ▫ No

Are you on Birth Control? ▫ Yes ▫ No Are you post-menopausal? ▫ Yes ▫ No

<u>MOHS Consultation Patients ONLY</u>

Location of the growth to be removed? ________________ How long has the growth been present? _______________

Has the growth been treated previously? ______________ Is it growing? - Yes – No Immunosuppression - Yes - No

<u>Does the growth do the following</u>: Bleed? - Yes - No Ulcerate? - Yes - No Tingle? - Yes - No

<u>Do you have a history of</u>: X-Ray treatments for acne - Yes - No Chronic Scarring - Yes - No

X____________________________________ _____________ X___________________________ ____________

Signature of Patient Date Signature of Medical Provider Date