SKIN SURGERY CENTER OF VIRGINIA

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Medical History Form

Patient Name: _____ Date: _____

Sex: [ ] Male [ ] Female Date of Birth: _____ Accompanied by: _____

Consult requested by: [ ] Dr. _____ Referred by: [ ] Self [ ] Friend _____

Reason for today's visit: [ ] Mohs [ ] Skin Cancer Monitoring [ ] Suspicious Lesion [ ] Rash [ ] Acne [ ] Hair Loss
[ ] Other _____

History of today's problem(s) only: **[ ] No problem today** **[ ] Problems today are listed below**

	Problem # 1	**Problem # 2**	**Problem # 3**
Skin areas involved:			
How long present?			
Previously biopsied?			
Treatment? *(When/Type)*:			

Check all that apply to today's problem(s): **[ ]** Not Applicable

Associated Symptoms
[ ] Bleeding [ ] Tingling [ ] Itching [ ] Scaly [ ] Pain/sore/tender [ ] Burning [ ] Spreading [ ] Redness [ ]Other [ ] None

Height_____ **Weight**_____

Past Medical History *(Check all that apply and add any other important problems)*

[ ] None [ ] High Blood Pressure [ ] Diabetes [ ] Pregnant [ ] Breastfeeding
[ ] Heart Disease [ ] HIV/AIDS [ ] Depression [ ] Anxiety Attacks [ ] Heart Valve Dysfunction
[ ] Hepatitis B [ ] Stroke [ ] Faints Easily [ ] RA/Lupus [ ] Tuberculosis
[ ] Hepatitis C [ ] Renal Failure [ ] Pacemaker [ ] Hepatitis/Cirrhosis [ ] Leukemia/Lymphoma
[ ] Platelet dysfunction [ ] Artificial Joint [ ] Blood Transfusions [ ] Organ Transplant [ ] Myelodysplastic Synd.
[ ] Cancer [ ] Radiation Therapy [ ] Dementia [ ] High Cholesterol [ ] History of MRSA/Staph
[ ] Abnormal Scarring/Keloids [ ] Needs Antibiotics prior to Dental Procedure [ ] Implantable Neurological Device

Do you have a **pacemaker?** [ ] Yes [ ] No Do you have a **defibrillator?** [ ] Yes [ ] No

Previous Skin Cancer: [ ] No [ ] Yes, please list location, date and treatments: _____

_____

Other Major Illnesses, Surgeries, Hospitalizations [ ] No [ ] Yes, please list: _____

_____

Family history of skin cancer? [ ] None [ ] Basal Cell [ ] Squamous Cell [ ] Melanoma

What is your occupation? _____ Is English your main language? [ ] Yes [ ] No _____

Do you have any problems with mobility? [ ] No [ ] Yes _____

Do you have religious, cultural, spiritual practices that might affect how we treat you? [ ] No [ ] Yes _____

Do you have any problems with your vision or hearing that might affect how we treat you? [ ] No [ ] Yes _____

Smoking/Tobacco Status (this includes all forms of tobacco products)

- ☐ Current- Year started_____
- ☐ Former- Year started_____ Year stopped_____
- ☐ Type of tobacco product_____
- ☐ Never

Alcohol Status

How many times in the last year have you had 5 or more drinks in one sitting? _____

Flu Vaccine

- ☐ Previously immunized- date (include month and year)_____
- ☐ Not immunized

Pneumonia Vaccine

- ☐ Previously immunized- date (include month and year) _____
- ☐ Not immunized

Patient Medication Information

Date: _____ Name: _____ Date of Birth: _____

****Required Pharmacy Information:**

Pharmacy Name: _____ Pharmacy Phone: _____

Are you **allergic** to any medications?

[ ] No, I have no known allergies to medication [ ] Yes, I have an allergy to the medication(s) listed below:

Medication: _____ Medication: _____

Medication: _____ Medication: _____

Please list all medications that you are currently taking: **Prescribed and Over the counter medications** Please include dosage and how often you take them			