D.O.B. ____________ **MEDICAL HISTORY FORM** Valley Skin Cancer Surgery

PATIENT NAME: ______________________ **DATE:** ____________

Reason for visit: ______________________

Medications (including over the counter and herbal):

Do you take antibiotics before dental procedures? ☐ No ☐ Yes

DRUG ALLERGIES: ☐ None ☐ Yes
(List medication and type of reaction)

Allergies or bad reaction to local (numbing) anesthesia
☐ No ☐ Yes, (*what reaction?*)

Major illnesses, hospitalization, & surgeries (include year)

History of skin cancer: ☐ No ☐ Yes
(include type, location, year):

History of cancer (other than skin) & TX:

SYSTEM REVIEW: Check all that apply regarding your health

SKIN
- ☐ Acne
- ☐ Abnormal scarring/ Keloids
- ☐ Eczema / Dermatitis
- ☐ Psoriasis
- ☐ Other: ______

INFECTIONS
- ☐ *NONE*
- ☐ Cold sores / Herpes
- ☐ Hepatitis/Jaundice
- ☐ HIV/AIDS
- ☐ Tuberculosis (TB)
- ☐ Other: ______

ALLERGY
- ☐ *NONE*
- ☐ Hay fever
- ☐ Food allergies ______
- ☐ Hives
- ☐ Other: ______

CARDIOVASCULAR
- ☐ *NORMAL*
- ☐ High blood pressure
- ☐ Heart murmur
- ☐ Artificial valve
- ☐ Pacemaker ☐ Defibrillator
- ☐ Heart transplant
- ☐ Varicose veins/ Poor circulation
- ☐ Other ______

ENDOCRINE
- ☐ *NORMAL*
- ☐ Diabetes
- ☐ Thyroid disease (hyper or hypo)
- ☐ Kidney disease
- ☐ Kidney transplant
- ☐ Other: ______

GYN
- ☐ Pregnant, What month? ______
- ☐ Breast feeding
- ☐ Other:

Gastrointestinal
- ☐ *NORMAL*
- ☐ Stomach ulcer
- ☐ Colitis
- ☐ Liver damage
- ☐ Liver transplant
- ☐ Other: ______

HEMATOLOGIC/LYMPHATIC
- ☐ *NORMAL*
- ☐ Anemia
- ☐ Bleeding problems
- ☐ Blood transfusion
- ☐ Immunosuppression
- ☐ Other: ______

MUSCULOSKELETAL
- ☐ *NORMAL*
- ☐ Arthritis
- ☐ Artificial joint
- ☐ Other: ______

NEUROLOGICAL
- ☐ *NORMAL*
- ☐ Stroke
- ☐ Seizure
- ☐ Other: ______

PSYCHIATRIC
- ☐ *NORMAL*
- ☐ Anxiety attacks
- ☐ Depression
- ☐ Other: ______

RESPIRATORY
- ☐ *NORMAL*
- ☐ Asthma
- ☐ Emphysema/Bronchitits
- ☐ Other: ______

EAR /EYES/NOSE/THROAT
- ☐ *NORMAL*
- ☐ Glaucoma
- ☐ Other: ______

FAMILY HISTORY:

Skin cancer: ☐ None ☐ Melanoma ☐ Basal cell ☐ Squamous cell ☐ Don't know type?

Who had it? ______

Other skin diseases:

SOCIAL HISTORY: Smoking/other tobacco products: ☐ No ☐ Former ☐ Yes, packs per day ______

Alcohol: ☐ None ☐ Yes, If yes, how much?

Skin type:
- ☐ Always burns, never tans
Extremely sun sensitive
- ☐ Burns easily, then tans a little
Very sun sensitive
- ☐ Sometimes burns, then tans slowly
Sun sensitive
- ☐ Burns a little, always tans
- ☐ Rarely burns, tans easily
- ☐ Never burns, deeply colored