

Patient Name _____ Date _____
Last First Middle

Age ____ Sex M F Referred by Self/Friend Dr. _____

Reason for & Location of today's problem _____

How long has the problem been present? _____

Was there any previous treatment? Yes No When? _____ Type? _____

Was a biopsy done? No Yes Biopsy done by referring Dr. Other _____

ALLERGIES None List _____

MEDICATIONS None Aspirin, last taken _____ blood thinners, last taken _____

LIST ALL MEDICATIONS, Vitamins, & Herbal supplements

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

SKIN	KIDNEY	CONSTITUTIONAL SYMPTOMS	EYES/EARS/NOSE/THROAT
<input type="checkbox"/> abnormal scarring	<input type="checkbox"/> normal	<input type="checkbox"/> none	<input type="checkbox"/> normal
<input type="checkbox"/> poor healing	<input type="checkbox"/> dialysis	<input type="checkbox"/> weight loss	<input type="checkbox"/> glaucoma
<input type="checkbox"/> other skin disorders _____	<input type="checkbox"/> other kidney problems _____	<input type="checkbox"/> fever	<input type="checkbox"/> hearing aid
		<input type="checkbox"/> other _____	<input type="checkbox"/> plastic surgery
RESPIRATORY	GASTROINTESTINAL	MUSCULOSKELETAL	NEUROLOGICAL
<input type="checkbox"/> normal	<input type="checkbox"/> normal	<input type="checkbox"/> normal	<input type="checkbox"/> normal
<input type="checkbox"/> asthma	<input type="checkbox"/> stomach ulcer	<input type="checkbox"/> arthritis	<input type="checkbox"/> stroke
<input type="checkbox"/> emphysema	<input type="checkbox"/> colitis	<input type="checkbox"/> artificial joint	<input type="checkbox"/> seizures
<input type="checkbox"/> other lung problem(s) _____	<input type="checkbox"/> other GI problems _____	<input type="checkbox"/> other _____	<input type="checkbox"/> other _____
HEMATOLOGIC/LYMPHATIC	ENDOCRINE	CARDIOVASCULAR	INFECTIONS
<input type="checkbox"/> normal	<input type="checkbox"/> normal	<input type="checkbox"/> normal	<input type="checkbox"/> none
<input type="checkbox"/> anemia	<input type="checkbox"/> diabetes	<input type="checkbox"/> chest pain	<input type="checkbox"/> hepatitis
<input type="checkbox"/> bleeding problems	<input type="checkbox"/> thyroid	<input type="checkbox"/> artificial heart valve	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> enlarged lymph nodes	<input type="checkbox"/> other _____	<input type="checkbox"/> pacemaker	<input type="checkbox"/> tuberculosis (T.B.)
<input type="checkbox"/> transfusion	_____	<input type="checkbox"/> high blood pressure	<input type="checkbox"/> transplant
<input type="checkbox"/> pregnant	_____	<input type="checkbox"/> mitral valve prolapse	<input type="checkbox"/> other _____
		<input type="checkbox"/> heart attack (when?) _____	
		<input type="checkbox"/> other _____	

PAST HISTORY

Previous skin cancer none list: _____

Location and date _____

Major illnesses or surgeries none list: _____

FAMILY HISTORY

Skin cancer none melanoma basal cell squamous cell other, list: _____

SOCIAL HISTORY

Occupation _____ Marital status: S M D W

Spouse name _____ Previous sunlight exposure or sunburns: mild moderate extensive

Do you wear: dentures glasses contact lenses Smoker: no yes, packs/day _____ former

Alcohol: no yes # of drinks per week _____ Alcohol or drug problems/addictions: no describe _____