The Dermatologic Surgery Center of Washington, LLC
Skin Cancer Treatment Center, LLC
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PATIENT MEDICAL HISTORY FORM

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Referred By: _____ Regular Physician: _____

Occupation: _____ Employer: _____ Sex: ○ Male ○ Female

What is the reason for your visit today? _____

When did you notice it? _____ Is it now: ○ Better ○ Worse ○ No Change

Drug Allergies (please check and list type of reaction): ☐ No Known Allergies

☐ Anesthetics _____
☐ Codeine _____
☐ Penicillin _____
☐ Tetracycline _____
☐ Aspirin _____
☐ Erythromycin _____
☐ Sulfa _____
☐ Other Drugs _____

Non-Drug Allergies: _____
(include reactions) _____

Current Medications:

Name / Strength / Dose

1. _____
2. _____
3. _____

Name / Strength / Dose

4. _____
5. _____
6. _____

Do you require Pre-Medication prior to any surgery? ○ No ○ Yes (Describe) _____

For what reason? _____

MEDICAL HISTORY:

Do you have or have you ever had a history of: (Please check all that apply)

☐ Acne	☐ Diabetes	☐ HIV disease	☐ Rheumatic fever
☐ Anemia	☐ Eczema	☐ Hives	☐ Scarring/keloids
☐ Arthritis	☐ Epilepsy	☐ Infections, chronic	☐ Skin cancer
☐ Asthma	☐ Fainting spells	☐ Kidney disease	☐ STD/Venereal disease
☐ Bleeding, excessive	☐ Glaucoma	☐ Liver disease	☐ Stroke
☐ Blood clots	☐ Hair loss	☐ Loss of skin pigment	☐ Thyroid disease
☐ Breathing disorder	☐ Hay fever	☐ Lung disease	☐ Tuberculosis
☐ Bruise easily	☐ Headaches, chronic	☐ Lupus	☐ Ulcers, skin
☐ Cancer: _____	☐ Heart problems	☐ Malignant melanoma	☐ Ulcers, intestinal
☐ Cataracts	☐ Hepatitis	☐ Mitral valve prolapse	☐ Varicose veins
☐ Colon/intestinal disorder	☐ Herpes simplex (cold sores)	☐ Neurological problems	☐ Vitiligo
☐ Convulsions/seizures	☐ Herpes zoster (shingles)	☐ Pacemaker	☐ Warts
☐ Depression	☐ High blood pressure	☐ Psoriasis	☐ Wound healing difficulty
☐ Other _____	☐ Other _____	☐ Other _____	

Females ☐ Chronic vaginal infection ☐ Taking oral contraceptives ☐ Nursing
☐ Currently pregnant ☐ Possibly pregnant Date of last menstrual period _____

SURGICAL HISTORY:

Type of Surgery	Date of Surgery
_____	_____

1.
2. _____ _____
3. _____ _____
4. _____ _____

COSMETIC PROCEDURES:

Type Date

1. _____ _____
2. _____ _____

SOCIAL HISTORY:

Has your weight changed in the last 6 months? ○ Yes ○ No Loss: _____ lbs Gain: _____ lbs

Do you use tobacco? ○ Yes ○ Never ○ Quit

If yes, how much per day? _____ How long? _____

Do you use drink alcohol? ○ Yes ○ Never ○ Quit

If yes, how much? _____ How often? _____

Do you use recreational drugs? ○ Yes ○ Never ○ Quit

If yes, how much? _____ How long? _____

Marital Status: ○ S ○ M ○ W ○ D

FAMILY HISTORY:

Please check if you have a family history of:

- ☐ Allergies
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Collagen Vascular Disease
- ☐ Diabetes
- ☐ Eczema
- ☐ Hay Fever
- ☐ Melanoma
- ☐ Psoriasis
- ☐ Skin Cancer

OTHER PERTINENT HISTORY:

1. _____
2. _____
3. _____
4. _____

PHYSICIAN'S NOTES:

Date: _____

_____ Initials: _____

Date: _____

_____ Initials: _____

Date: _____

_____ Initials: _____