

Name: _____ Today's Date: _____
Last First Middle

SS# : _____ - _____ - _____ Patient's Date of Birth: _____

I. Chief Complaint

What is the main reason for your visit ? _____

II. History of the Present Illness

Please Check All That Apply:

My doctor referred me for Mohs surgery. Please provide name of referring doctor: _____

I have biopsy proven skin cancer(s) (please fill in table below)

	Biopsy Diagnosis:	Location	Date of Biopsy	Has the area been treated before ?	How long has the area been present ?	Please check all that apply to this area:
Biopsy #1	<input type="checkbox"/> Basal cell <input type="checkbox"/> Squamous cell <input type="checkbox"/> Melanoma <input type="checkbox"/> Other:			<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, method:		<input type="checkbox"/> Painful <input type="checkbox"/> Won't heal <input type="checkbox"/> Bleeding <input type="checkbox"/> Increase in size <input type="checkbox"/> Change in color
Biopsy #2	<input type="checkbox"/> Basal cell <input type="checkbox"/> Squamous cell <input type="checkbox"/> Melanoma <input type="checkbox"/> Other:			<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, method:		<input type="checkbox"/> Painful <input type="checkbox"/> Won't heal <input type="checkbox"/> Bleeding <input type="checkbox"/> Increase in size <input type="checkbox"/> Change in color
Biopsy #3	<input type="checkbox"/> Basal cell <input type="checkbox"/> Squamous cell <input type="checkbox"/> Melanoma <input type="checkbox"/> Other:			<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, method:		<input type="checkbox"/> Painful <input type="checkbox"/> Won't heal <input type="checkbox"/> Bleeding <input type="checkbox"/> Increase in size <input type="checkbox"/> Change in color

III. Medications (please list the name, dosage & frequency of all medications including over the counter agents, vitamins, minerals, and supplements) Please use separate sheet of paper if necessary.

Name	Dosage	Frequency

I am currently not taking any medications, vitamins or other supplements.

IV. Allergies

Allergy	Reaction
1.	
2.	
3.	

Allergy	Reaction
4.	
5.	
6.	

I have no known allergies

Patient Name: _____ Patient Date of Birth: _____

Additional Comments: _____

V. Past Medical History: Do You Have a History of Any of the Following?

	Yes	No
Abnormal / Keloid Scarring	<input type="radio"/>	<input type="radio"/>
Antibiotics (Do you normally take before surgical /dental procedures)	<input type="radio"/>	<input type="radio"/>
Artificial Joints	<input type="radio"/>	<input type="radio"/>
Bleeding Problems	<input type="radio"/>	<input type="radio"/>
Cochlear Implant	<input type="radio"/>	<input type="radio"/>
Did you grow up on a tobacco farm	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>
Difficulty Healing Wounds	<input type="radio"/>	<input type="radio"/>
Do you have a history of radiation therapy	<input type="radio"/>	<input type="radio"/>
Glaucoma	<input type="radio"/>	<input type="radio"/>
High Blood Pressure	<input type="radio"/>	<input type="radio"/>
Immune System Problems (including HIV / AIDS)	<input type="radio"/>	<input type="radio"/>

	Yes	No
Artificial Heart Valve	<input type="radio"/>	<input type="radio"/>
Do you have Cardiac Stents	<input type="radio"/>	<input type="radio"/>
Heart Disease	<input type="radio"/>	<input type="radio"/>
Mitral Valve Prolapse	<input type="radio"/>	<input type="radio"/>
Pace Maker/Defibrillator	<input type="radio"/>	<input type="radio"/>
Rheumatic Fever	<input type="radio"/>	<input type="radio"/>
Kidney Disease	<input type="radio"/>	<input type="radio"/>
Liver Disease / Hepatitis	<input type="radio"/>	<input type="radio"/>
Lung Disease	<input type="radio"/>	<input type="radio"/>
Organ Transplantation	<input type="radio"/>	<input type="radio"/>
Peripheral Vascular Disease	<input type="radio"/>	<input type="radio"/>
Psychiatric Disease	<input type="radio"/>	<input type="radio"/>

If yes to any of the above please explain: _____

Cancer History:	Yes	No	If yes explain/list:
Melanoma	<input type="radio"/>	<input type="radio"/>	
Basal Cell Carcinoma	<input type="radio"/>	<input type="radio"/>	
Squamous Cell Carcinoma	<input type="radio"/>	<input type="radio"/>	
Other cancer(s)	<input type="radio"/>	<input type="radio"/>	

Please List Any Other Medical Problems, Prior Surgeries (with dates), or hospitalizations:

VI. Social History: Occupation: _____ Employer: _____

	Yes	No	If yes state amount (circle most appropriate):
Smoke tobacco	<input type="radio"/>	<input type="radio"/>	Packs per day: < 1/2 1.0 1-2 2-3 >3
Chew/Snuff	<input type="radio"/>	<input type="radio"/>	

New Patient History Form

Form D

Drink alcohol	<input type="radio"/>	<input type="radio"/>	Number of drinks per week: <1	1	1-4	7	>7
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VII. Family History

Do You Have a Family History of Any of the Following?

	Yes	No
Skin Cancer	<input type="radio"/>	<input type="radio"/>
Melanoma	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>
Heart disease	<input type="radio"/>	<input type="radio"/>

	Yes	No
High Blood Pressure	<input type="radio"/>	<input type="radio"/>
Bleeding problems	<input type="radio"/>	<input type="radio"/>
Other types of cancer	<input type="radio"/>	<input type="radio"/>

VIII. Review of Systems

Have you experienced any of the following symptoms in the past few months?

Symptom:	Yes	No
Fever	<input type="radio"/>	<input type="radio"/>
Weight Loss	<input type="radio"/>	<input type="radio"/>
Fatigue	<input type="radio"/>	<input type="radio"/>
Night Sweats	<input type="radio"/>	<input type="radio"/>
Burning sensation in eyes	<input type="radio"/>	<input type="radio"/>
Scratchy eyes	<input type="radio"/>	<input type="radio"/>
Excessive tearing	<input type="radio"/>	<input type="radio"/>
New or growing bump on eyelid	<input type="radio"/>	<input type="radio"/>
Bleeding from mouth or nose	<input type="radio"/>	<input type="radio"/>
Pain in mouth or nose	<input type="radio"/>	<input type="radio"/>
New or growing bump in mouth or nose	<input type="radio"/>	<input type="radio"/>
Cough	<input type="radio"/>	<input type="radio"/>
Shortness of breath	<input type="radio"/>	<input type="radio"/>
Chest Pain	<input type="radio"/>	<input type="radio"/>
Leg swelling	<input type="radio"/>	<input type="radio"/>
Leg pain with exercise	<input type="radio"/>	<input type="radio"/>
Allergy to lidocaine or numbing medicines	<input type="radio"/>	<input type="radio"/>

Symptom:	Yes	No
Abdominal pain	<input type="radio"/>	<input type="radio"/>
Nausea or vomiting	<input type="radio"/>	<input type="radio"/>
Blood in stools	<input type="radio"/>	<input type="radio"/>
Black stools	<input type="radio"/>	<input type="radio"/>
Persistent rashes in groin area	<input type="radio"/>	<input type="radio"/>
New growths in groin area	<input type="radio"/>	<input type="radio"/>
Bleeding in groin area	<input type="radio"/>	<input type="radio"/>
Bone pain	<input type="radio"/>	<input type="radio"/>
Arthritis	<input type="radio"/>	<input type="radio"/>
New skin growths or bumps	<input type="radio"/>	<input type="radio"/>
Changing skin lesions	<input type="radio"/>	<input type="radio"/>
Enlarged glands	<input type="radio"/>	<input type="radio"/>
Painful skin lesions	<input type="radio"/>	<input type="radio"/>
Burning sensation in skin	<input type="radio"/>	<input type="radio"/>
Loss of sensation in skin	<input type="radio"/>	<input type="radio"/>
Headaches	<input type="radio"/>	<input type="radio"/>
Weakness	<input type="radio"/>	<input type="radio"/>
Visual problems	<input type="radio"/>	<input type="radio"/>

Explain below if you answered yes above:
