

## New Patient History Form

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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 all medications including over the counter agents, vitamins, minerals, and supplements)

1.	4.	7.	10.
2.	5.	8.	11.
3.	6.	9.	12.

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

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Patient Name: \_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_

Additional Comments: \_\_\_\_\_

### V. Past Medical History

Do You Have a History of Any of the Following?

	Yes	No		Yes	No
Bleeding Problems	<input type="radio"/>	<input type="radio"/>	Peripheral Vascular Disease	<input type="radio"/>	<input type="radio"/>
Difficulty Healing Wounds	<input type="radio"/>	<input type="radio"/>	High Blood Pressure	<input type="radio"/>	<input type="radio"/>
Keloids	<input type="radio"/>	<input type="radio"/>	Heart Disease	<input type="radio"/>	<input type="radio"/>
Abnormal Scarring	<input type="radio"/>	<input type="radio"/>	Lung Disease	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	Kidney Disease	<input type="radio"/>	<input type="radio"/>
Rheumatic Fever	<input type="radio"/>	<input type="radio"/>	Liver Disease / Hepatitis	<input type="radio"/>	<input type="radio"/>
Artificial Heart Valve	<input type="radio"/>	<input type="radio"/>	Glaucoma	<input type="radio"/>	<input type="radio"/>
Pace Maker	<input type="radio"/>	<input type="radio"/>	Psychiatric Disease	<input type="radio"/>	<input type="radio"/>
Artificial Joints	<input type="radio"/>	<input type="radio"/>	Mitral Valve Prolapse	<input type="radio"/>	<input type="radio"/>
Immune System Problems	<input type="radio"/>	<input type="radio"/>	Antibiotics	<input type="radio"/>	<input type="radio"/>
Cochlear Implant	<input type="radio"/>	<input type="radio"/>	Organ Transplantation	<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"/>	
Drink alcohol	<input type="radio"/>	<input type="radio"/>	Number of drinks per week: <1    1    1-4    7    >7

## New Patient History Form

### 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:

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