



Advanced Dermatology
Skin Cancer and Laser Surgery Center, P.C.
PATIENT HEALTH SUMMARY

(Please Print)

Today's Date: _____

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

Referring Physician: _____ Phone # _____

Primary Care Physician: _____ Phone # _____

Preferred Pharmacy (Name, Location and Phone #): _____

Contact Information

Do you give our office permission to discuss your medical information with family members, including but not limited to : biopsy results, blood/ lab results, or other test results? Yes No If yes, please provide their names and numbers below.

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

Do you give permission for Advanced Dermatology staff to leave detailed messages at your preferred contact number regarding any tests that you may incur as a patient, including but not limited to : biopsy results, blood/lab results, or other test results? Yes No

Preferred Contact Method: Home _____ Cell _____ Work _____

Medication Allergies: _____

Reason for Today's Visit: _____

Have you been previously diagnosed with any of the following? Please indicate any medical problems not listed below in the "Other" box.

- Grid of medical conditions with checkboxes: Anxiety, Arthritis, Asthma, Atrial Fibrillation, Blood Clots, BPH, Bone Marrow Transplant, Breast Cancer, Colon Cancer, COPD, Coronary Heart Disease, Depression, Diabetes, End Stage Renal Disease, GERD, Hearing Loss, Heart Valve Replacement, Hepatitis, HIV/AIDS, High Blood Pressure, High Cholesterol, Hyperthyroidism, Hypothyroidism, Joint Replacement, Leukemia, Lung Cancer, Lymphoma, Prostate Cancer, Radiation Treatment, Seizures, Stroke, Other.

Past Surgical History: Please use other side if needed to list additional surgeries

- 1) _____ 3) _____
2) _____ 4) _____

Have you had any of the following skin conditions?

- Grid of skin conditions with checkboxes: Acne, Actinic Keratosis, Asthma, Basal Cell Carcinoma, Blistering Sunburn, Dry Skin, Eczema, Flaky/ Itchy Scalp, Hay Fever/Allergies, Melanoma *, Poison Ivy, Precancerous Moles, Psoriasis, Squamous Cell Carcinoma *, Other.

List all medications you are currently taking (including prescriptions, over-the-counter, vitamins, and herbals): Please use other side if needed to list additional medications.

- 1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

PATIENT HEALTH SUMMARY

-Continued-

Has anyone in your family had skin cancer? Yes No If Yes, who and what type: _____
 Do you have a family history of Melanoma? Yes No If Yes, who: _____
 Do you use sunscreen? Yes No If Yes, what SPF: _____
 Do you use a tanning bed? Yes No
 Do you drink alcohol? Yes No If Yes, how much: 1 drink /day 1-2 drinks/day 3+per day
 Do you smoke? Never Former Current If Yes, how much per day: _____

Is there a family history (In Mother, Father, or Siblings) of the following conditions? If yes, which family member?

- | | | |
|--------------------------------------------------------|----------------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> Breast Cancer _____ | <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Colon Cancer _____ | <input type="checkbox"/> High Cholesterol _____ | _____ |
| <input type="checkbox"/> Coronary Artery Disease _____ | <input type="checkbox"/> Lung Cancer _____ | <input type="checkbox"/> Unknown Family History |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Pancreatic Cancer _____ | <input type="checkbox"/> Unknown Family History -Adopted |
| | <input type="checkbox"/> Prostate Cancer _____ | |

REVIEW OF SYSTEMS/ALERTS INFO

Do you develop skin rashes or reactions to: Medications Food Environment Bandages (Adhesives) Antibiotic Ointment
 Do you develop keloid scars? (Firm, thick scars) Yes No
 Do you bleed easily? Yes No If Yes, is patient on blood thinners? _____
 Do you have an Artificial Heart Valve? ** Yes No
 Have you had Artificial Joints within the last 2 years? ** Yes No
 Do you have a Defibrillator or Pacemaker? Yes No
 Do you have a history of MRSA? (Resistant Bacterial Infection) Yes No
 Do you require antibiotics prior to procedures? Yes No
 Do you develop rapid heartbeat to Epinephrine? Yes No
 If applicable: Are you pregnant? Yes No Breastfeeding? Yes No

 Reviewed By Date

Additional Surgical History- Continued from the front side

- | | |
|----------|-----------|
| 5) _____ | 8) _____ |
| 6) _____ | 9) _____ |
| 7) _____ | 10) _____ |

Additional Medications- Continued from the front side

- | | |
|-----------|------------|
| 7.) _____ | 10.) _____ |
| 8.) _____ | 11.) _____ |
| 9.) _____ | 12.) _____ |

