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 _____

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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.

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation (Irregular Heartbeat)
- ☐ Blood Clots
- ☐ BPH (Enlarged Prostate)
- ☐ Bone Marrow Transplant
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Heart Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD (Acid Reflux)
- ☐ 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?

- ☐ 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?

- ☐ Breast Cancer _____
- ☐ Colon Cancer _____
- ☐ Coronary Artery Disease _____
- ☐ Diabetes _____
- ☐ High Blood Pressure _____
- ☐ High Cholesterol _____
- ☐ Lung Cancer _____
- ☐ Pancreatic Cancer _____
- ☐ Prostate Cancer _____
- ☐ Other _____
- ☐ Unknown Family History
- ☐ Unknown Family History -Adopted

If you are 65 years of age or older, have you had a pneumonia vaccination? Yes No

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

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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.)_____