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:** _____

Medication Allergies: _____

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

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) _____ 3) _____

2) _____ 4) _____

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

Do you have a family history of Basal Cell or Squamous Cell 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: _____

-PLEASE COMPLETE OTHER SIDE-

PATIENT HEALTH SUMMARY
-Continued-

For patients 65 years of age or older.

Have you had a pneumonia vaccination? Yes No
Do you have a healthcare proxy in the event you are unable to make your own medical decisions? Yes No

REVIEW OF SYSTEMS/ALERTS INFO- ALL PATIENTS

Do you develop skin rashes or reactions to:	Medications	Food	Environment	Bandages (Adhesives)	Antibiotic Ointment
Do you have an allergy to Iodine/Betadine?		Yes	No		
Do you have an allergy to Lidocaine?		Yes	No		
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		
Do you have Artificial Joints? **		Yes	No	If Yes, what year was your replacement? _____	
Do you require antibiotics prior to procedures?		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 develop rapid heartbeat to Epinephrine?		Yes	No		
Do you have an allergy to latex?		Yes	No		
If applicable:	Are you planning a pregnancy?	Yes	No		
	Are you currently pregnant?	Yes	No		
	Are you 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

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