Raleigh Skin Surgery Center, pllc

ACMS American College of Mohs Surgery
Fellowship trained skin cancer and reconstructive surgeons

3100 Duraleigh Road; Suite 201 • Raleigh, NC 27612 • Phone: (919) 390-0200 Fax: (919) 390-0219

Medical History Form

Patient's Name: ____

Home Phone #: __________________________ Alternate Phone # : _________________________ ☐work ☐cell

Physicians (your referring physician will automatically receive a copy of your operative report):

What physician referred you to our office? Physician's Name: ____

Practice Name: ____

Who is your primary care physician? Physician's Name: ____

Practice Name: ____

Drug Allergies

Do you have **drug allergies** or reactions to medications? ☐Yes ☐No
If yes, please list drug allergies or sensitivities and your reaction:

Drug	Reaction
________________________	____
________________________	____
________________________	____

Are you allergic to any types of **sutures or tapes?** ☐Yes ☐No

Have you had an organ transplant? ☐Yes ☐No
If yes, what organ? Why? ____

Do you take aspirin? ☐Yes ☐No

Do you take Coumadin (warfarin)? ☐Yes ☐No

Do you take Plavix? ☐Yes ☐No

Do you take NSAIDs (Aleve, Daypro, Voltaren, Motrin, Advil, Ibuprofen)? ☐Yes ☐No
If yes, when was your most recent dose? _________________________

Do you take a Multivitamin, Vitamin E, or Ginkgo Biloba? ☐Yes ☐No

Have you been advised to take antibiotics before surgery or dental work? ☐Yes ☐No
If yes, why? _____________________ Which antibiotic? _______________________________

Please list below all current medications (include dosage, if known):

______________________________ ______________________________ ______________________________
______________________________ ______________________________ ______________________________
______________________________ ______________________________ ______________________________
______________________________ ______________________________ ______________________________
______________________________ ______________________________ ______________________________
______________________________ ______________________________ ______________________________

Pharmacy of choice: ____________________________________ Phone #: _________________________________

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Social History

Do you perform strenuous work or engage in strenuous hobbies? ☐Yes ☐No

Do you use tobacco in any form? ☐Yes ☐No If yes, amount per day: ____________________

Do you use alcohol? ☐Yes ☐No If yes, amount per day: ____________________

Family History

Has anyone in your immediate family had melanoma? ☐Yes ☐No

Has anyone in your family had other forms of skin cancer? ☐Yes ☐No

Past Medical History / Review of Systems

Do you have a history of any of the following or symptoms related to these areas (check yes or no)?

Cardiovascular	Yes	No
Pacemaker	☐	☐
Defibrillator	☐	☐
Stents	☐	☐
Heart valve disease	☐	☐
Artificial heart valves	☐	☐
Angina (chest pain)	☐	☐
Irregular rhythm (atrial fibrillation)	☐	☐
Myocardial infarction (heart attack)	☐	☐
Stroke (CVA) or Mini Stroke (TIA)	☐	☐

Skin	Yes	No
Difficulty healing	☐	☐
Keloid scars	☐	☐

Musculoskeletal	Yes	No
Artificial Joints	☐	☐
Swollen Ankles	☐	☐

Gastrointestinal/Genitourinary	Yes	No
Hepatitis	☐	☐
Diabetes Mellitus	☐	☐
Nausea / vomiting	☐	☐

Allergic / Immunologic	Yes	No
AIDS / HIV infection	☐	☐

Eyes, Ears, Nose and Throat	Yes	No
Tearing eyes (chronic)	☐	☐
Glaucoma	☐	☐
Hearing difficulty	☐	☐
Gum disease	☐	☐

Hematologic	Yes	No
Bleeding Problems	☐	☐
Anemia	☐	☐
Lupus	☐	☐

Constitutional	Yes	No
Night sweats	☐	☐
Enlarged lymph nodes	☐	☐
Fever	☐	☐
Kidney / bladder problems	☐	☐
Cancer (other than skin cancer)	☐	☐

Respiratory	Yes	No
Cough	☐	☐
Shortness of breath	☐	☐
Supplementary oxygen	☐	☐

Please print and sign your form, be sure to bring it with you to your appointment.

SIGN HERE

____________________________________ ____________________

Patient's Signature **Date**

For Physician Use Only:

Date Reviewed	Reviewed By (initial)	Date Reviewed	Reviewed By (initial)	Date Reviewed	Reviewed By (initial)

Patient Label