Raleigh Skin Surgery Center, pllc

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

3811 Ed Drive; Suite 110 • Raleigh, NC 27612 • Phone: (919) 390-0200 Fax: (919) 390-0219

Medical History Form *(Front & Back)*

Patients Name: _____ DOB: _____ Height: _____ Weight: _____

Home Phone #: _____ Alternative Phone #: _____ ☐work ☐cell

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

What physician referred you to our office?

Physicians Name: _____
Practice Name: _____

Who is your primary care physician?

Physicians 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 **latex?**----------☐Yes ☐No
Are you allergic to any **adhesive in tapes or sutures?** ------ ☐Yes ☐No

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

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

Social History:

Are you wheelchair bound?----------☐Yes ☐No
Do you perform strenuous work/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: _____

Do you *normally* take any of the following medications:

			If ***yes,*** when did you take your most recent dose?
Aspirin----------	☐Yes	☐No	_____
Coumadin (Warfarin)----------	☐Yes	☐No	_____
Plavix (Clopidogrel)----------	☐Yes	☐No	_____
NSAIDS (Aleve, Daypro, Motrin, Advil, Ibuprofen)	☐Yes	☐No	_____
Vitamins/Supplements (multivitamin, fish oil, etc.)	☐Yes	☐No	_____

Please list below all current medications with dosage (include vitamins/supplements, over-the-counter medications):

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pharmacy of choice: _____ Street & City: _____

Patient Label

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Family History of Skin Cancer:

Has anyone in your immediate family (blood relative) had melanoma? ☐Yes ☐No

Has anyone in your family (blood relative) 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)	☐	☐
Hypertension (High Blood Pressure)	☐	☐
Elevated Cholesterol	☐	☐
Vasovagal (history of fainting/lightheadness)	☐	☐

Skin	Yes	No
Slow Healing	☐	☐
Keloid scars (extremely thick scars)	☐	☐
Previous BCC (Basal Cell Carcinoma)	☐	☐
Previous SCC (Squamous Cell Carcinoma)	☐	☐
Previous Melanoma	☐	☐
Other Skin Cancer: _____	☐	☐

Respiratory	Yes	No
Emphysema/ Bronchitis/ COPD	☐	☐
Shortness of breath	☐	☐
Supplementary oxygen	☐	☐
Sleep apnea (CPAP)	☐	☐

Musculoskeletal	Yes	No
Artificial Joints	☐	☐
Swollen Ankles	☐	☐

Gastrointestinal/Genitourinary	Yes	No
Hepatitis	☐	☐
Diabetes	☐	☐
Frequent/long-term nausea/vomiting	☐	☐

Allergic / Immunologic	Yes	No
AIDS / HIV infection	☐	☐
History of MRSA	☐	☐

Eyes, Ears, Nose and Throat	Yes	No
Tearing eyes (chronic)	☐	☐
Hearing difficulty	☐	☐
History of Cold Sores/Fever Blisters	☐	☐

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

Constitutional	Yes	No
Enlarged lymph nodes	☐	☐
Kidney problems	☐	☐
Cancer (other than skin cancer)	☐	☐

Sign Here Only _____ _____

Patient's Signature **Date**

Patient's Signature Date

Patient's Signature Date

Patient's Signature Date

For Physician Use Only:

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

Patient Label