DFW Skin Surgery Center PLLC

1115 W. Randol Mill Rd
Suite 200
Arlington, TX 76012

2485 E. Southlake Blvd
Suite 200
Southlake, TX 76092

: (817) 303-MOHS (6647)
: (817) 303-6651
: www.dfwskinsurgery.com

MEDICAL HISTORY FORM

Patient Name: _____ Date: _____ Date of Birth: _____

Do you have or have you ever had any of the following (check all that apply)?

☐ Previous skin cancer / Melanoma
If yes, please list locations and dates: _____
_____
_____
☐ Keloids
☐ Poor wound healing
☐ Prolonged bleeding / bleeding disorder
☐ Skin infections
☐ Blood transfusions
☐ Infectious hepatitis
☐ HIV
☐ Leukemia / lymphoma
☐ Other cancer
If yes, please list and indicate whether in remission:
_____
☐ Organ transplant
☐ High blood pressure
☐ Heart murmur
☐ Rheumatic fever
☐ Artificial joint or heart valve
☐ Heart disease / Heart attack
☐ Stroke / TIA
☐ Cold sores
☐ Eczema
☐ Psoriasis
☐ Asthma / hay fever / hives / sinus problems
☐ Heart burn / ulcers / reflux disease
☐ Kidney disease
☐ Renal failure
☐ Glaucoma
☐ Diabetes
☐ Tuberculosis
☐ Autoimmune disease
☐ Surgery/hospitalizations
If yes, please list: _____
_____
☐ Other: _____

Have any blood relatives ever had any of the following (check all that apply)?

☐ Skin cancer
If yes, who: _____
☐ Melanoma
If yes, who: _____
☐ Abnormal moles
☐ Poor healing / keloids
☐ Psoriasis
☐ Asthma / hay fever / eczema
☐ Diabetes
☐ Other skin disease: _____

Are you allergic to any medications?

☐ No ☐ Yes (please list medications and reactions):
_____

Are you currently taking any medications or supplements?

☐ No ☐ Yes (please list): _____
_____
_____

Social history:

Do you smoke?
☐ No ☐ Yes (how much): _____
Do you drink?
☐ No ☐ Yes (how much): _____
Do you sunbathe or use tanning beds?
☐ No ☐ Yes (how often): _____
Do you use sunscreen?
☐ No ☐ Yes (what SPF number): _____

Female patients only:

Are you currently pregnant?
☐ No ☐ Yes
If not pregnant, do you plan to become pregnant in the near future?
☐ No ☐ Yes
Are you nursing?
☐ No ☐ Yes

To the best of my knowledge, the information provided on this form is correct. I understand that providing incorrect information may be dangerous to my or my child's health. It is my responsibility to inform the office of any changes in my or my child's medical status.

Patient or Guardian Signature: _____ Date: _____/_____/_____
Relationship (if other than patient): _____