DFW Skin Surgery Center PLLC

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MEDICAL HISTORY FORM

Patient Name: _____ 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 / MRSA carrier
☐ Blood transfusions
☐ Infectious hepatitis B or C
☐ HIV Current viral load, if known: _____
☐ Leukemia / lymphoma / multiple myeloma
☐ Other cancer (please list and indicate if in remission)
_____
_____
☐ Organ transplant Organ: _____ Date: _____
☐ High blood pressure
☐ Heart murmur
☐ Artificial joint / replacement Latest date: _____
☐ Heart valve replacement ☐ Metal ☐ Biological (pig or cow)
☐ Heart attack
☐ Stroke / TIA
☐ Cold sores
☐ Eczema
☐ Psoriasis
☐ Asthma or seasonal allergies
☐ Reflux disease or ulcers
☐ Kidney disease
☐ Renal failure
☐ Fainting with needles / injections
☐ Diabetes
☐ Tuberculosis
☐ Autoimmune disease
☐ Falls ☐ Check if twice or more in the last year
☐ 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
☐ Other skin disease: _____
☐ Diabetes
☐ Other cancer

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

Current medications (include dosages and how often):
_____
_____
_____
_____
_____
_____

Height: _____ Most recent weight: _____

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.

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