BAY AREA SKIN CANCER SURGERY AND DERMATOLOGY

To help evaluate your present, past, and future health concerns, please provide us with the following information.

Name: _____ Date of Birth: ____/____/____
(Last, First, Middle) (month, day, year)

How would you prefer to be addressed? Please circle

First name Mr. Mrs. Ms. Other: _____

Past Medical History: Please circle all that apply

Anxiety	Depression	Hypothyroidism
Arthritis	Diabetes	Leukemia
Asthma	End Stage Renal Disease	Lung Cancer
Atrial fibrillation (irregular heartbeat)	GERD (Acid reflux)	Lymphoma
Bone marrow transplantation	Hearing Loss	Prostate Cancer
BPH (Benign Prostatic Hyperplasia)	Hepatitis	Radiation Treatment
Breast Cancer	Hypertension	Seizures
Colon Cancer	HIV/AIDS	Stroke
COPD (Emphysema)	Hypercholesterolemia	Other: _____
Coronary artery disease	Hyperthyroidism	_____

Past Surgical History: Please circle all that apply

Appendix (appendectomy)	Colon: Inflammatory Bowel Disease
Bladder (cystectomy)	Gallbladder: Cholecystectomy
Breast: Mastectomy (Right breast)	Heart: Coronary Artery Bypass Surgery
Breast: Mastectomy (Left breast)	Heart: PTCA
Breast: Mastectomy (Both breasts)	Heart: Mechanical Valve Replacement
Breast: Lumpectomy (Right breast)	Heart: Biological Valve Replacement
Breast: Lumpectomy (Left breast)	Heart: Heart Transplant
Breast: Lumpectomy (Both breasts)	Joint Replacement: Knee (Right)
Breast: Biopsy	Joint Replacement: Knee (Left)
Breast: Reduction	Joint Replacement: Knees (Both)
Breast: Implants	Joint Replacement: Hip (Right)
Colon: Colon Cancer Resection	Joint Replacement: Hip (Left)
Colon: Diverticulitis	Joint Replacement: Hips (Both)

Past Surgical History, Continued: Please circle all that apply

Kidney: Kidney Biopsy	Ovaries: Ovarian Cancer	Skin: Squamous Cell Cancer
Kidney: Nephrectomy (removal)	Prostate: Prostate Cancer	Skin: Melanoma
Kidney: Kidney Stone Removal	Prostate: Prostate Biopsy	Spleen: Splenectomy
Kidney: Kidney Transplant	Prostatectomy: TURP	Testicles Removed
Ovaries: Endometriosis	Skin: Skin Biopsy	Uterus: Fibroids
Ovaries: Ovarian Cyst	Skin: Basal Cell Carcinoma	Uterus: Uterine Cancer

Other: _____

Skin Disease History: Please circle all that apply

Acne	Dry Skin	Poison Ivy
Actinic Keratoses	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Cancer	Hay Fever/ Allergies	Squamous Cell Cancer
Blistering Sunburns	Melanoma	Other: _____

Do you wear sunscreen? Yes _____ No _____ If yes, what SPF? _____

Do you tan in a tanning salon? Yes _____ No _____

Do you have a family history of melanoma? Yes _____ No _____

If yes, which relative? (please circle all that apply)

Mother	Brother	Uncle	Niece	Grandson
Father	Daughter	Aunt	Grandmother	Grandaughter
Sister	Son	Nephew	Grandfather	Other: _____

Medications: Please enter all current medications, including over the counter and herbs, **and their correspond ing dosages**

1) _____ _____mg Frequency: once a day twice a day three times a day

2) _____ _____mg Frequency: once a day twice a day three times a day

3) _____ _____mg Frequency: once a day twice a day three times a day

4) _____ _____mg Frequency: once a day twice a day three times a day

5) _____ _____mg Frequency: once a day twice a day three times a day

6) _____ _____mg Frequency: once a day twice a day three times a day

Medications, Continued

7) _____ _____mg Frequency: once a day twice a day three times a day

8) _____ _____mg Frequency: once a day twice a day three times a day

9) _____ _____mg Frequency: once a day twice a day three times a day

10) _____ _____mg Frequency: once a day twice a day three times a day

11) _____ _____mg Frequency: once a day twice a day three times a day

12) _____ _____mg Frequency: once a day twice a day three times a day

Allergies: Please enter all allergies, including allergy to tape, topical antibiotics, and local anesthesia

_____

Social History: Please circle one

Cigarette Smoking:

Current every day smoker	Never smoker
Current some day smoker (tobacco)	Heavy tobacco smoker
Current some day smoker (cigarette)	Light tobacco smoker
Former smoker	

Number of packs per day: _____ Total # of years smoking: _____

Alcohol Use:	Exercise:	Caffeine use:
Never	Never	Never
Less than one drink per day	A few times a month	A few times a month
One to two drinks per day	A few times a week	A few times a week
Three or more drinks per day	Once a day	Once a day
	Several times a day	Several times per day

Occupation: (past and present) _____

Place of Residence: (please circle) Home, Assisted Living, Nursing Home, Other: _____