Name: _____ Date of Birth: _____

PLEASE FILL OUT BOTH SIDES

Past Medical History: (please circle all that apply)

Anxiety	Coronary Artery	HIV/AIDS
Arthritis	Disease	Leukemia
Asthma	Depression	Lymphoma
Atrial fibrillation	Diabetes	Radiation Treatment
Bacterial Endocarditis	Renal Disease	Seizures
	Hepatitis	Stroke
	High Blood pressure	NONE

Other _____

Past Surgical History: (please circle all that apply)

Coronary Artery Bypass	Joint Replacement, Hip (Right, Left, Bilateral)
Mechanical Valve Replacement	
Biological Valve Replacement	Kidney Transplant
Heart Transplant	Liver Transplant
Joint Replacement, Knee (Right, Left, Bilateral)	NONE

Other _____

Skin Disease History: (please circle all that apply)

Actinic Keratoses		Squamous Cell Skin Cancer
Basal Cell Skin Cancer	Melanoma	
Blistering Sunburns	Precancerous Moles	NONE

Other

_____

_____

Do you have a family history of
Melanoma? Yes No

If Yes circle who- Mother Father Sister Brother

Medications: (Please enter all current medications)

_____

_____

_____

_____

_____

PLEASE FILL OUT BOTH SIDES

Allergies: (Please enter all allergies)

_____

_____

Social History: (Please circle all that apply)

Cigarette Smoking:

Currently Smokes
Never smoked
Former Smoker

Alcohol Use:

None
less than 1 drink per day
1-2 drinks per day
3 or more drinks per day

Other_____

For what are you being seen?:_____

Where on your body is it?:_____

How is it bothering you?:_____

How severe do you think it is: Mild Moderate Severe

How long has it been there?:_____

How has it been Treated?: Biopsy Excision Frozen Scraped Other:_____

Do you have: (**circle if yes**)

Problems with Bleeding Problems with Healing Problems with Scarring

Unintentional weight loss Pacemaker and/or Defibrillator Artificial Heart Valve

Have you received a **Flu shot** this year? Yes No

Have you ever received the **Pneumonia Vaccine**? Yes No

For Office Staff- Data entered _____