Bainbridge Skin Surgery
*Consultative Dermatology*

## MEDICAL HISTORY INFORMATION

| Patient Name | Date of Birth | Age | Gender |
|---|---|---|---|
| Referring Provider & Clinic Name | | Phone Number<br>(        ) | |
| Primary Care Physician & Clinic Name | | Phone Number<br>(        ) | |

Pharmacy Name:

Pharmacy Phone: (            )

**Do you have an Advance Directive (Living Will)?**

- o Yes – Please provide us a copy (See Patient's Rights)
- o No

List (or attach) all *current medications* and their dose:

______________________________________________
______________________________________________
______________________________________________
______________________________________________

List (or attach) *allergies to medications*:

______________________________________________
______________________________________________
______________________________________________
______________________________________________

## SOCIAL HISTORY

**TOBACCO/SMOKING STATUS**

- o None
- o Former use
- o Current use
  Cigarettes / Cigars / Chewing Tobacco
  _____ packs per day
  _____ total years smoking

**ALCOHOL USE**

- o None
- o Less than 1 drink per day
- o 1-2 drinks per day
- o 3+ drinks per day

**DRUG USE**

- o None
- o Yes; please list:
  ______________________
  ______________________
  ______________________

**PHYSICAL ACTIVITY**

How often do you exercise?

______ times per week

**OCCUPATION/WORKPLACE**

Occupation: ____________________

Workplace: ____________________

- o Retired

**RESIDENCE HISTORY**

Where did you grow up?

## PAST MEDICAL HISTORY

**UV/SUN EXPOSURE**

- o Excessive
- o Moderate
- o History of tanning bed use
- o Current tanning bed use
- o Sunscreen use; SPF ________

**PERSONAL HISTORY**

Skin Cancer

- o None
- o Basal Cell
- o Squamous Cell
- o Melanoma

**FAMILY HISTORY**

Skin Cancer

- o None
- o Basal Cell
- o Squamous Cell
- o Melanoma
  Relationship______________

**OTHER SKIN CONDITIONS**

- o Acne
- o Actinic Keratoses
- o Blistering Sunburns
- o Dry Skin
- o Eczema
- o Flaking or Itchy Scalp
- o Poison Ivy
- o Precancerous Moles
- o Psoriasis
- o Other: ____________________

**CARDIOVASCULAR**

- o Normal
- o Atrial Fibrillation
- o Artificial Valve
- o Coronary Artery Disease
- o Chest Pain
- o Heart Attack (when?):
  ________ / ________
- o Hypertension
- o Pacemaker / Defibrillator
- o Other: ____________________

**MUSCULOSKELETAL**

- o Normal
- o Arthritis
- o Joint Aches
- o Joint Replacement
  Hip: Right / Left / Both
  Knee: Right / Left / Both
- o Muscle Weakness
- o Neck Stiffness
- o Other: ____________________

***OVER***

| ENDOCRINE | HEMATOLOGIC/LYMPHATIC | INFECTIONS |
|---|---|---|
| ○ Normal<br>○ Diabetes<br>○ Hyperthyroidism<br>○ Hypothyroidism<br>○ Other: ____________________ | ○ Normal<br>○ Anemia<br>○ Bleeding Problems<br>○ Bone Marrow Transplant<br>○ Leukemia / Lymphoma / Myeloma<br>○ Other: ____________________ | ○ None<br>○ Hepatitis ____ A ____ B ____ C<br>○ HIV/AIDS<br>○ Staph<br>○ Tuberculosis (TB)<br>○ Other: ____________________ |
| **GASTROINTESTINAL** | **RESPIRATORY** | **NEUROLOGICAL** |
| ○ Normal<br>○ Abdominal Pain<br>○ Bloody Stool<br>○ Bloody Urine<br>○ Colitis<br>○ GERD<br>○ Stomach Ulcer<br>○ Other: ____________________ | ○ Normal<br>○ Asthma<br>○ COPD<br>○ Cough<br>○ Emphysema<br>○ Shortness of Breath<br>○ Wheezing<br>○ Other: ____________________ | ○ Normal<br>○ Alzheimer's / Dementia<br>○ Headaches<br>○ Seizures<br>○ Stroke<br>○ Other: ____________________ |
| **INTEGUMENTARY** | **CONSTITUTIONAL** | **ALLERGIC/IMMUNOLOGIC** |
| ○ Normal<br>○ Rash<br>○ Healing Problems<br>○ Scarring Problems<br>○ Other: ____________________ | ○ Normal<br>○ Fever / Chills<br>○ Night Sweats<br>○ Unintentional Weight Loss<br>○ Other: ____________________ | ○ Normal<br>○ Immunosuppression<br>○ Hay Fever<br>○ Other: ____________________ |
| **GENITOURINARY** | **EAR/NOSE/THROAT & EYES** | **PSYCHIATRIC** |
| ○ Normal<br>○ Bladder Problems<br>○ BPH (male)<br>○ Kidney Disease<br>○ Other: ____________________ | ○ Normal<br>○ Hearing Loss<br>○ Sore Throat<br>○ Blurry Vision<br>○ Macular Degeneration<br>○ Other: ____________________ | ○ Normal<br>○ Anxiety<br>○ Depression<br>○ Other: ____________________ |

| SURGICAL HISTORY | MEDICAL CONDITIONS |
|---|---|
| List (or attach) all *surgeries* and/or *hospitalizations* (please include approximate dates):<br>________________________________________<br>________________________________________<br>________________________________________<br>________________________________________<br>________________________________________<br>________________________________________<br>________________________________________<br>________________________________________ | List (or attach) any *medical conditions* not listed above:<br>________________________________________<br>________________________________________<br>________________________________________<br>________________________________________<br>________________________________________<br>________________________________________<br>________________________________________<br>________________________________________ |

*I have completed this form to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the physician's office of any changes in medical status.*

**Signature of Patient, Parent or Guardian:** ______________________________ **Date:** ________________

Printed Name & Relationship (if other than patient): ________________________________________

**If signing as Power of Attorney, please provide a copy of Power of Attorney documentation.*