Name: ____ **Date of Birth**:___________________
Age: ___________ Sex: ________ Height: _________ Weight: ___________

Preferred **Pharmacy**: ____________________________ Pharmacy Phone: _________________
Pharmacy Address: ____

Referring Physician Name and Phone: ____
Primary Care Physician Name and Phone: ____

Reason for Todays Visit: ____

Skin area affected: ________________________ How long has it been present? ____________

Was a biopsy done? _______________________Who did Biopsy? _______________________

Have you had skin cancer before? ____
Have you had Mohs Surgery before? _____________
If yes, who performed the Mohs Surgery ____

Circle all that apply regarding todays problem: None
Change in: Size Color Elevation Hardness
History of: Bleeding Tingling Itching Pain Ulceration Infection
Risk Factors: X-ray Treatments UV light Treatments Arsenic Exposure Immunosuppression

Medications: (Please provide all current medications and doses if not previously provided, or please provide a list to us)
____
____
____
____

Drug Allergies: (Please enter all allergies and what happens when you encounter them)
Please check here if you have none

Allergy	**Reaction**

Latex Allergy: Yes No

GALLOWAY
DERMATOLOGIC SURGERY

Past Medical History: (please check all that apply)

Check ALL that apply regarding your overall health and add any other medical problems:

CARDIOVASCULAR
☐*Normal*
☐Artificial valve
☐Pacemaker
☐High blood pressure
☐Heart Attack (when?)
☐High Cholesterol
☐Bypass/other surgery
☐Mitral valve prolapse
☐Other heart problem

GASTROINTESTINAL
☐*Normal*
☐Stomach Ulcer
☐Colitis
☐Irritable bowel
☐Reflux

NEUROLOGICAL
☐*Normal*
☐Stroke
☐Seizures
☐Alzheimer's
☐Parkinson's

PSYCHIATRIC
☐*Normal*
☐Depression
☐Anxiety disorder.
☐Other

BLOOD/LYMPH
☐*Normal*
☐Enlarged lymph nodes
☐Anemia
☐Bleeding problems

RESPIRATORY
☐*Normal*
☐Emphysema
☐Asthma

ENDOCRINE
☐*Normal*
☐Diabetes
☐Thyroid problem

SKIN
(besides skin cancer)
☐*Normal*
☐Poor/slow healing
☐Keloids

GENERAL
☐*Normal*
☐Fever/Weight loss

INFECTIONS
☐*Normal*
☐Hepatitis
☐HIV/AIDS
☐Tuberculosis
☐MRSA

MUSCULOSKELETAL
☐*Normal*
☐Arthritis
☐Fibromyalgia
☐Artificial joint (date installed)

HEAD/NECK
☐*Normal*
☐Hearing aid
☐Glaucoma
☐Plastic surgery

Other____
____

Past Surgical History:
(please list all **NON**-SKIN CANCER-RELATED surgeries and dates they were performed)
Please check if you have not had any surgeries

Surgery	Date

Skin Disease History: (please circle all that apply

Acne
Actinic Keratoses
Asthma
Basal Cell Skin
Cancer
Blistering
Sunburns
Dry Skin

Eczema
Flaking or Itchy
Scalp
Hay
Fever/Allergies
Melanoma
Poison Ivy

Precancerous
Moles
Psoriasis
Squamous Cell
Skin Cancer

NONE

Do you wear Sunscreen? Yes No If yes, what SPF? ___________
Do you tan in a tanning salon? Yes No

GALLOWAY
DERMATOLOGIC SURGERY

Patient Name:

Family Medical History:
Do you have a family history of Melanoma? Yes No
If yes, which relative(s)?
____

Do you have a family history of other skin cancers? Yes No
Do you have a family history of Bleeding Problems? Yes No

Family Medical History:
Please Check for First Degree Relative Only

- Anxiety
- Arthritis
- Asthma
- Atrial fibrillation
- Organ Transplantation
- Breast Cancer
- Colon Cancer
- COPD
- Coronary Artery Disease
- Depression
- Diabetes
- End Stage Renal Disease
- GERD
- Hepatitis
- High Blood pressure
- HIV/AIDS
- High Cholesterol
- Thyroid Problems
- Leukemia
- Lung Cancer
- Lymphoma
- Prostate Cancer
- Radiation Treatment
- Seizures
- Stroke
- NONE

Social History:
(Please check all that apply)

Cigarette Smoking:
- Never smoked
- Former Smoker
- Currently Smokes

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

Occupation: ____
Marital Status: _______________________
Do you wear: Dentures Glasses Contacts (circle if yes)

GALLOWAY
DERMATOLOGIC SURGERY

Patient Name:

Have you had a flu shot in the past year? ☐No ☐Yes
Have you ever had the pneumonia vaccine? ☐No ☐Yes

Age 65 and older ONLY: Do you have an advanced care plan? YES NO

ALERTS: (please check any and all that apply)

Allergy to Adhesive
Allergy to topical antibiotics
Artificial heart valve
- mechanical vs tissue? ______________________

Artificial joint replacement
- if yes, which joint(s) and when was the surgery? _______________________

Blood thinners
Defibrillator
History of MRSA infection
Pacemaker
Require antibiotics prior to a surgical procedure
Pregnant or currently trying to get pregnant