Patient Identification

SOUTH END DERMATOLOGY & SKIN CARE

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PLEASE COMPLETE THIS FORM AND BRING IT WITH YOU TO YOUR APPOINTMENT

MOHS PATIENT MEDICAL HISTORY

Date:___________________________________

Who referred you to the Mohs Surgery Center? ____

Who is your Primary care physician?____

When did you first notice this problem?____

Skin area(s) involved?____

Has this area been treated before? ☐ Yes ☐ No

If yes, when and how?____

Was this area ever affected by a burn, scar, or trauma? ☐ Yes ☐ No

Please check all that apply to your current skin problem

Change in: ☐ Size ☐ Color ☐ Elevation ☐ Other

Associated symptoms: ☐ Bleeding ☐ Numbness ☐ Pain ☐ Itching ☐ Infection ☐ Scabbing ☐ Other ____

Severity of symptoms: ☐ None ☐ Occasional ☐ Symptoms ☐ Constant Symptoms

MEDICATIONS

Please list all the medicines you are currently taking, including eye and ear drops, inhalers or breathing medicines, aspirin, herbals, vitamins and supplements.

Name/Dose	# Times Per Day
1.______________________________	
2.______________________________	
3.______________________________	
4.______________________________	
5.______________________________	
6.______________________________	

ALLERGIES to medications: i.e. Novocaine, Lidocaine, or any antibiotics. ☐ Yes ☐ No

If there is an allergy, what is your allergic response?

1.____

2.____

3.____

4.____

ALLERGIES to latex, adhesive tape, or Band-Aids? ☐ Yes ☐ No

Medical History

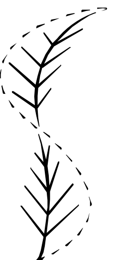
Do you have history of: ☐ Excessive diagnostic x-ray ☐ Medical light treatments ☐ Immunosuppression ☐ Arsenic exposure ☐ Sunlamp/tanning bed use ☐ Welding arc ☐ Radiation therapy

How many times?________ Date(s) Treated___________________________________

Have you ever had skin cancer? ☐ Yes ☐ No

If yes, when and where on your skin?____

Have you ever had melanoma? ☐ Yes ☐ No



How long ago was your first skin cancer?____

Have any of your family members been diagnosed with skin cancer? ☐ Yes ☐ No

Type____

____

____

Have any of your family members been diagnosed with melanoma? ☐ Yes ☐ No

If yes, please list person/relationship to you.____________________________________

Was the melanoma fatal? ☐ Yes ☐ No

Do you burn easily in the sun? ☐ Yes ☐ No

When in the direct sun (one hour) do you burn?

☐ Always ☐ Usually ☐ Sometimes ☐ Minimal ☐ Never

How well do you tan? ☐ Always ☐ Gradually ☐ Minimal ☐ Never

Have you ever had a blistering sunburn? ☐ Yes ☐ No

When?__________________________ How many times?__________________________

Did you have freckles? ☐ Yes ☐ No

Original hair color?_________________________ Color of eyes?__________________________

Did you have numerous moles as teenager or young adult? ☐ Yes ☐ No

Have you had abnormal moles removed surgically? ☐ Yes ☐ No

How many?____

Excessive recreational sun exposure? (i.e. golf, tennis, boating, gardening, sunbathing, fishing, mountains, beach) ☐ Yes ☐ No

Number of years you performed outdoor recreation_____________________________

Outdoor hours per week____

Have you spent many days on a boat? How many?______________________________

Do you routinely use sunscreens, hats, sun protective clothing or avoid sun exposure to minimize further skin damage by the sun? ☐ Yes ☐ No

Are you currently or possibly pregnant? ☐ Yes ☐ No

Are you currently breastfeeding? ☐ Yes ☐ No

Have you ever had a wound infection or infection after surgery? ☐ Yes ☐ No

Do you have an infection anywhere? ☐ Yes ☐ No

Have you worked with pesticides, insecticides, industrial solvents? ☐ Yes ☐ No

If yes, was this on the job exposure?____

Social History

What is your occupation?____

Have you ever worked an outdoor occupation? ☐ Yes ☐ No

If yes, what type of outdoor work?____

Number of years/months?_________________ Outdoor hours per day_____________

Did you serve in the armed forces? ☐ Yes ☐ No

If yes, how long?_________________, Where?____________________________

Hours outdoor per week?____________________

Do you live ☐ at home alone; ☐ with spouse, ☐ partner, ☐ children, ☐ pet

Do/did you smoke? ☐ Yes ☐ No ____packs per day ____number of years

Do you drink alcohol? ☐ Yes ☐ No ____drinks per day ____drinks per week

Do you abuse substances such as alcohol, recreational drugs or inhalents? ☐ Yes ☐ No

Does anyone in your home cause you to be afraid for your safety? ☐ Yes ☐ No

Do you use seatbelts? ☐ Yes ☐ No

Do you have any of the following *(please circle or fill in the blank)*

Skin problems (psoriasis, poor healing, abnormal scarring, inflammed skin)? ☐ Yes ☐ No
If yes, please list:____

Gastrointestinal problems (ulcers, hepatitis, jaundice, liver disease) ☐ Yes ☐ No
If yes, please list:____

History of cold sores/facial herpes ☐ Yes ☐ No

Neurologic problems (stroke, Alzheimer's, seizures, TIA) ☐ Yes ☐ No
If yes, please list:____

Cochlear implants (surgically implanted hearing aid) ☐ Yes ☐ No

Cardiovascular problems (heart attack, abnormal heart beat, chest pain, high blood pressure, stent, heart failure, bypass, heart defect, pacemaker, heart murmur, valve replacement, rheumatic fever, implanted cardiac defibrillator) ☐ Yes ☐ No
If yes, please list:____

Kidney disease ☐ Yes ☐ No

Infectious disease (hepatitis, TB) ☐ Yes ☐ No

History of organ transplantation? ☐ Yes ☐ No
If yes, please list organ and dates of transplant surgery______________________________
____

Joint replacement, artificial heart valve or any other surgically implanted prostheses ☐ Yes ☐ No

Asthma/Chronic Lung Disease ☐ Yes ☐ No

Diabetes ☐ Yes ☐ No
If yes, how is it controlled (diet, oral medication, insulin injections)____________________
____

History of excessive bleeding or bleeding after medical procedures? ☐ Yes ☐ No

Have you had a blood clot in your legs, lungs? ☐ Yes ☐ No

Any history of endocrine (hormonal) disease? ☐ Yes ☐ No
If yes, please list:____

Have you ever had any operation to unclog or bypass arteries? ☐ Yes ☐ No

Do you take blood thinning medicine? ☐ Yes ☐ No
If yes, please list:____

Have your blood thinner tests been erratic (too high or too low) in the past or have you been told to stop taking the blood thinner due to abnormal blood tests results? ☐ Yes ☐ No

Do you have glaucoma? ☐ Yes ☐ No

History of autoimmune disorders (rheumatoid arthritis, lupus) ☐ Yes ☐ No
If yes, please list:____
____

Any history of emotional problems? ☐ Yes ☐ No

Have you ever had cancer (other than skin cancer)? ☐ Yes ☐ No
If yes, please list type and date diagnosed and therapy______________________________
____

Has anyone in your family (siblings or parents) had cancer? ☐ Yes ☐ No
If yes, please list:____
____

Any other major medical problems (not discussed previously)? ☐ Yes ☐ No
If yes, please explain____

All previous surgeries and dates?____
____
____

Have you had difficulty with healing? ☐ Yes ☐ No
Do you have prominent scarring? ☐ Yes ☐ No
Have you had cosmetic surgery? ☐ Yes ☐ No
Do any diseases run in your family? ☐ Yes ☐ No
Do you require antibiotics before dental work? ☐ Yes ☐ No

Are you currently under care of a Visiting Nurse? ☐ Yes ☐ No
Name and phone number of Visiting Nurse____________________________________
Who can help with you with wound dressing changes?_______________________________

Physician Signature: ______________________________ Date: ____________________