COASTAL
SKIN SURGERY & DERMATOLOGY

## ***PERSONAL MEDICAL INFORMATION***

***Pharmacy Name*** _____ ***Telephone*** _____

***CURRENT MEDICATIONS*** **(may also provide a list)**:

_____ _____ _____

_____ _____ _____

_____ _____ _____

***REVIEW OF SYSTEMS*** **(Current or Past Problems)**

- **Major Surgeries/Hospitalization**

_____

_____

_____

***HISTORY of Skin Cancer***

***Personal***: **(if yes, give dates and location on body)**

**Basal Cell** **Y N** _____

_____

**Squamous Cell** **Y N** _____

_____

**Melanoma** **Y N** _____

_____

***Family:*** ___**Basal Cell** ____ **Squamous Cell** ____ **Melanoma**

**Details:** _____

***PERSONAL HISTORY***:

| | | | | | |
|---|---|---|---|---|---|
| Heart Attack | **Y N** | Stroke | **Y N** | Non Skin Cancer | **Y N** |
| Heart Disease | **Y N** | Autoimmune Disease | **Y N** | Kind? _____ | **Y N** |
| Kidney Disease | **Y N** | Diabetes (Sugar) | **Y N** | Blood/Bleeding disorder | **Y N** |
| Liver Disease | **Y N** | High Blood Pressure | **Y N** | Infectious Disease? | |
| Lung Disease | **Y N** | Thyroid Disease | **Y N** | TB | **Y N** |
| Other: _____ | | Hepatitis | **Y N** | HIV | **Y N** |

Do you have a pacemaker/Defibrillator? **Y N**
Do you have an artificial joint/heart valve? **Y N**
Do you take antibiotics prior to procedures? **Y N**
Do you form keloids or thick scars? **Y N**

***Allergies*** (Medication/Drug/Food):_____

| | | | |
|---|---|---|---|
| Allergic to Iodine? | **Y N** | Allergic to X-Ray/IVP Dye? | **Y N** |
| Allergic to Latex? | **Y N** | Nickel or Metal Allergy? | **Y N** |
| Allergic to Adhesive? | **Y N** | | |

***Social History***

| | | | |
|---|---|---|---|
| Do you smoke? | **Y N** | How much? _____ | |
| Did you smoke in the past? | **Y N** | How long? _____ | |
| Drink Alcohol? | **Y N** | Socially/Occasionally _____ | Heavily _____ |
| Use tanning beds? | **Y N** | Have you in the past? | **Y N** |

***Occupation:*** _____

_____ _____

***Signature of Patient*** ***Date***