ARKANSAS DERMATOLOGY
SKIN CANCER CENTER
MEDICAL • SURGICAL

DERMATOLOGY MEDICAL HISTORY

Patient Name:_____ Date: _____ Referring Physician(if any)_____

- Problems with bleeding? Yes No
- Problems with healing? Yes No
- Problems with scarring? Yes No
- Do you have a rash? Yes No
- Immunosuppression? Yes No
- Hay fever? Yes No
- Chest pain? Yes No
- Thyroid problems? Yes No
- Abdominal pain? Yes No
- Joint aches? Yes No
- Neck stiffness? Yes No
- Headaches? Yes No
- Seizures? Yes No
- Cough? Yes No
- Shortness of breath? Yes No
- Wheezing? Yes No
- Anxiety? Yes No
- Depression? Yes No
- Allergy to adhesive? Yes No
- Allergy to lidocaine? Yes No
- Allergy to topical antibiotic ointments? Yes No
- Artificial heart valve? Yes No
- Do you take blood thinners? Yes No
- Artificial joints within the last 2 years? Yes No
- Do you have a defibrillator? Yes No
- Do you have MRSA? Yes No
- Do you have a pacemaker? Yes No
- Do you require premedication prior to procedures? Yes No
- Rapid heart beat with epinephrine? Yes No
- Are you pregnant or planning to become pregnant? Yes No
- Are you breastfeeding? Yes No
- Do you have a history of skin cancer? Yes No
- Do you have a family history of skin cancer? Yes No
- Do you have lupus? Yes No
- Have you had a lot of sun exposure? Yes No
- Have you had a flu shot? Yes No
- If 65 and older, have you had a pneumonia vaccine? Yes No
- Are you a smoker? Yes No
- If not, did you used to smoke? Yes No

PLEASE LIST ALL CURRENT MEDICATIONS AND DRUG ALLERGIES IN THE AREA PROVIDED BELOW. PLEASE INCLUDE AL OVER THE COUNTER MEDICINE, VITAMINS AND HERBAL THERAPIES.

Drug Allergies: _____ Nausea Itching Anaphylaxis

MEDICATIONS:

_____

_____

_____

_____

_____

DERMATOLOGY REVIEW OF SYSTEMS

Anxiety	Yes	No	Hearing Loss	Yes	No
Arthritis	Yes	No	Hepatitis	Yes	No
Asthma	Yes	No	Hypertension	Yes	No
Atrial Fibrillation	Yes	No	HIV/AIDS	Yes	No
Bone Marrow Transplantation	Yes	No	Hypercholesterolemia	Yes	No
Benign Prostatic Hyperplasia	Yes	No	Hyperthyroidism	Yes	No
Breast Cancer	Yes	No	Hypothyroidism	Yes	No
Colon Cancer	Yes	No	Leukemia	Yes	No
COPD	Yes	No	Lung Cancer	Yes	No
Coronary Artery Disease	Yes	No	Lymphoma	Yes	No
Depression	Yes	No	Prostate Cancer	Yes	No
Diabetes	Yes	No	Radiation Treatment	Yes	No
End Stage Renal Disease	Yes	No	Seizures	Yes	No
GERD	Yes	No	Stroke	Yes	No

Other Medical Conditions: _____

Past Surgical History

Appendix (Appendectomy)	Yes	No	Kidney: Kidney Transplant	Yes	No
Bladder (Cystectomy)	Yes	No	Kidney: Nephrectomy	Yes	No
Breast: Breast Biopsy	Yes	No	Liver: Hepatectomy	Yes	No
Breast: Lumpectomy (Both Breasts)	Yes	No	Liver Transplant	Yes	No
Breast: Lumpectomy (Left Breast)	Yes	No	Liver: Shunt	Yes	No
Breast: Lumpectomy (Right Breast)	Yes	No	Ovaries:		
Breast: Mastectomy (Both Breasts)	Yes	No	(Oophorectomy):Endometriosis	Yes	No
Breast: Mastectomy (Left Breast)	Yes	No	(Oophorectomy): Ovarian Cancer	Yes	No
Breast: Mastectomy (Right Breast)	Yes	No	(Oophorectomy): Ovarian Cyst	Yes	No
Colon (Colectomy): Colon Cancer	Yes	No	Ovaries: Tubal Ligation	Yes	No
Colon (Colectomy): Diverticulitis	Yes	No	Pancreas: Pancreatectomy	Yes	No
Colon (Colectomy): Inflammatory BD	Yes	No	Prostate: Prostate Biopsy	Yes	No
Colon: Colostomy	Yes	No	Prostate: Prostatectomy	Yes	No
Gallbladder (Cholecystectomy)	Yes	No	Prostate: TURP	Yes	No
Heart: Biological Valve Replacement	Yes	No	Rectum: APR	Yes	No
Heart: Coronary Artery Bypass Surgery	Yes	No	Rectum: Low Anterior Resection	Yes	No
Heart: Heart Transplant	Yes	No	Skin: Basal Cell Carcinoma	Yes	No
Heart: Mechanical Valve Replacement	Yes	No	Skin: Melanoma	Yes	No
Heart: PTCA	Yes	No	Skin: Skin Biopsy	Yes	No
Joint Replacement: Hip (Both)	Yes	No	Skin: Squamous Cell Carcinoma	Yes	No
Joint Replacement: Hip (Left)	Yes	No	Spleen (Splenectomy)	Yes	No
Joint Replacement: Hip (Right)	Yes	No	Testicles (Orchiectomy)	Yes	No
Joint Replacement: Knee (Both)	Yes	No	Uterus:		
Joint Replacement: Knee (Left)	Yes	No	(Hysterectomy): Fibroids	Yes	No
Joint Replacement: Knee (Right)	Yes	No	(Hysterectomy) Uterine Cancer	Yes	No
Kidney: Kidney Biopsy	Yes	No	(Hysterectomy):Cervical Cancer	Yes	No
Kidney: Kidney Stone Removal	Yes	No			

Other Surgical History: _____