PATIENT MEDICAL HISTORY

Name: _____ DOB: _____

Please check the following that apply:

☐ BASAL CELL CARCINOMA (BCC)

Area of body: _____ When: _____

Area of body: _____ When: _____

☐ SQUAMOUS CELL CARCINOMA (SCC)

Area of body: _____ When: _____

Area of body: _____ When: _____

☐ MELANOMA

Area of body: _____ When: _____

☐ ABNORMAL MOLES

Area of body: _____ When: _____

Area of body: _____ When: _____

Family History

Do you have any family history of skin cancer?

YES **NO**

If so, what type of skin cancer?

_____

☐ Eczema
☐ Psoriasis
☐ Hives
☐ Hay Fever/ allergies/ asthma
☐ Transplant of kidney or other organ
☐ Autoimmune disease (i.e. Lupus)
☐ Hepatitis/ liver disease
☐ Kidney disease
☐ Arthritis
☐ Diabetes

☐ Bleeding Disorders
☐ Stroke
☐ Cancer
☐ Fainting/seizures
☐ Headaches
☐ Heart disease/ valve disease
☐ Heart Murmur/rheumatic fever
☐ Ulcers/stomach/bowel disease
☐ Vision problems
☐ Thyroid disease

☐ Tuberculosis
☐ Artificial joints
☐ Artificial heart valve
☐ Latex allergy
☐ Pace maker
☐ Hepatitis A/hepatitis B/hepatitis C
☐ HIV
☐ Previous Surgeries: _____
☐ Other: _____

The above information is correct to the best of my knowledge.

Signature: _____ Date: _____

Parent / Guardian for minors: _____ Date: _____