

Skin Cancer Clinic of Seattle, Inc., P.S.

Cutaneous Surgery and Oncology – New Patient Health History

Date form completed: _____ **Name:** _____
 Your age: _____
 Occupation: _____
 Home phone #: _____
 Work or other phone #: _____

Dr. who sent you here: _____ Tel: _____ City: _____
 Your **Family** Dr.: _____ Tel: _____ City: _____
 Your **Heart** Dr.: _____ Tel: _____ City: _____
 Other Dr.: _____ Tel: _____ City: _____

Have you had a skin cancer treated by Mohs surgery before? NO / YES if yes, when? _____

Regarding the spot(s) that you were sent to us for:

1st Spot: Where is it on your body? _____
 How long have you had this spot? _____
 Has it been (circle) Itching? Painful? Bleeding? Growing? Crusting? Other: _____
 Has it been treated before? NO / YES if yes, please explain (example: Cut out by Dr. Smith, 7/98)

2nd Spot: Where is it on your body? _____
 How long have you had this spot? _____
 Has it been (circle) Itching? Painful? Bleeding? Growing? Crusting? Other: _____
 Has it been treated before? NO / YES if yes, please explain (example: cut out by Dr. Smith, 7/98)

Please list medications you take regularly.

MEDICATION	HOW OFTEN	MEDICATION	HOW OFTEN	MEDICATION	HOW OFTEN

Do you have any allergies to medications? (circle) NO / YES If yes, please explain.

1. _____ causes _____
2. _____ causes _____
3. _____ causes _____

 Physician Initial Nursing Initial Date Reviewed

PLEASE TURN OVER & CONTINUE

- Has any relative ever had a proven MELANOMA? NO / YES
- Do you smoke? NO / YES
- How much alcohol do you drink per day? _____
- Have you ever had a sunburn that peeled or blistered? NO / YES
- Please describe your skin (circle one only):
 - 1. I always burn and never tan.
 - 2. I always burn but sometimes tan.
 - 3. I always tan but sometimes burn.
 - 4. I never burn and always tan.
- What color are your eyes _____
- What color was your natural hair at age 20? _____
- Have you had radiation treatment to your skin? NO / YES If yes, where on your body & for what? _____

Please check either NO or YES in each row:

HEART	NO	YES	
Heart attack			→ When?
Angina/Chest Pain			→ Last time you felt it?
Arrhythmia (irregular heartbeat)			→
Pacemaker/Defibrillator (circle which)			→
Murmur			→
Artificial heart valve			→
Require antibiotics before procedures			→
Other heart problems			→
CONDITION	NO	YES	
Organ Transplant			→ Organ and date:
HIV/AIDS			→
Hepatitis/liver problems			→
Seizures			→ Last time you had one?
Stroke/Mini-stroke (TIA)			→ Last time you had one?
Lung problems, Asthma, Emphysema, Sleep Apnea			→ Do you need supplemental O ₂ or CPAP?
Diabetes			
High blood pressure			
Cancer (other)			→ Type:
Pregnant or breast feeding			→ Due date:
Auto immune disease (Lupus, scleroderma)			→
Artificial joints/pins			→
Bleeding problems			→
Psychiatric Disorder			→
Eye problems			→
Gastrointestinal disease			→
Thyroid problems			→
Skin Disorder			→

If you have had a **major** illness or **major** surgery in the past 5 years, please explain:

Month/Year
