BRYN MAWR SKIN & CANCER INSTITUTE

Medical Dermatology
CIRILLO INSTITUTE

Please complete front & back - 3 pages.

Medical History Form

Patient Name: _____ **DOB**: _____/_____/_____

Who Referred You? _____

Primary Care Physician: _____ **Phone**: _____

Note: If you have already used our online Patient Portal to complete pp. 1-2, please skip directly to p. 3.

List the physicians you see and their specialty?

_____
_____
_____
_____

Do you have a Pacemaker? **Yes** **No**

Do you have an AICD (automated implantable cardioverter-defibrillator)? **Yes** **No**

Are you an organ(s) transplant recipient? **Yes** **No**

Are you pregnant, nursing or planning a pregnancy? **Yes** **No**

Medications including over the counter supplements: *(Please enter all current medications, or attach a list)*

_____
_____
_____

Allergies: *(Please enter all allergies)*

_____
_____
_____

Preferred Pharmacy: _____ **Phone:** _____

Pharmacy Address: _____
_____
_____

Skin Disease History: *(Please circle all that apply)*

Acne	Blistering Sunburns	Keloid Scarring	Psoriasis
Actinic Keratosis	Dry Skin	Melanoma	Squamous Cell Skin Cancer
Basal Cell Skin Cancer	Eczema	Poison Ivy	
	Flaking or Itchy Scalp	Precancerous Moles (atypical)	None

Other _____

Bryn Mawr Office
919 Conestoga Road
Building Two, Suite 106
Bryn Mawr, PA 19010

Newtown Square Office
3855 West Chester Pike
Suite 325
Newtown Square, PA 19073

610.525.5028 TEL | 610.525.2494 FAX | BrynMawrSkin.com | CirilloInstitute.com

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Family History of: (Please circle all that apply) Melanoma Basal Cell Skin Cancer Squamous Cell Skin Cancer
If yes, which relative(s) _____

Do you wear Sunscreen? Yes No If yes, what SPF? _____
Do you tan in a tanning salon? Yes No

Alerts: *Please circle Yes or No.*

• **History of melanoma**	Yes	No
• **Allergy to adhesive**	Yes	No
• **Allergy to latex**	Yes	No
• **Allergy to lidocaine**	Yes	No
• **Allergy to topical antibiotic ointments**	Yes	No
• **Artificial heart valve**	Yes	No
• **Artificial joints within past 2 years**	Yes	No
• **Blood thinners**	Yes	No
• **Hepatitis C**		
• **HIV / AIDs**	Yes	No
• **MRSA** (methicillin resistant staph aureus**)**	Yes	No
• **Premedication prior to procedures**	Yes	No
• **Rapid heartbeat with epinephrine**	Yes	No

Other Alerts: _____

Past Medical History: *(Please circle all that apply)*

Anxiety	Colon Cancer	Hepatitis	Lymphoma
Arthritis	COPD	Hypertension	Prostate Cancer
Artificial joints	Coronary Artery Disease	HIV/AIDS	Radiation Treatment
Asthma	Depression	Hypercholesterolemia	Seizures
Atrial fibrillation	Diabetes	Hyperthyroidism	Stroke
BPH	End Stage Renal Disease	Hypothyroidism	Heart Valve Replacement
Bone Marrow Transplant	GERD (gastroesophageal)	Kidney Disease	
Breast Cancer	Hay fever Allergies	Leukemia	None
	Hearing Loss	Lung Cancer	

Other _____

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Past Surgical History: *(Please circle all that apply)*

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD (inflammatory bowel disease)
Gallbladder Removed
Coronary Artery Bypass
PTCA (Coronary Angioplasty)
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Kidney Biopsy
Kidney Removed (Right, Left)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP (transurethral resection of prostate)
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer

None

Review of Systems: *Are you currently experiencing any Symptoms?* *Please circle Yes or No.*

• **Problems with bleeding**	Yes	No
• **Problems with healing**	Yes	No
• **Immunosuppression**	Yes	No
• **GI upset with antibiotics**	Yes	No
• **Thyroid problems**	Yes	No

Other Symptoms: _____

Social History: *(Please check all that apply)*

Tobacco Use: Never Smoked ___ Quit: Former Smoker ___ Smoke less than daily ___ Smoke Daily ___

Other _____

History of high blood pressure in your family? Yes No If yes, who? _____

Do you drink alcohol and how often? ____ None ____ Less than 1 drink per day
____ 1-2 drinks per day ____ 3 or more drinks per day

(Please circle Yes or No)

Do you use Drugs?	Yes	No	Other____
Are you pregnant or nursing?	Yes	No	Other____
Do you have a living will?	Yes	No	Other____
If Yes, who is your Healthcare Proxy?			_____
Did you receive a flu shot this year?	Yes	No	Other____
Did you receive a pneumonia vaccine?	Yes	No	Other____