CIRILLO INSTITUTE
Bryn Mawr Skin & Cancer Institute
Cirillo Cosmetic Dermatology Spa
Cirillo Center for Plastic Surgery

Bryn Mawr Skin & Cancer Institute
Medical Dermatology

Cirillo Cosmetic Dermatology Spa
Cosmetic Dermatology

Cirillo Center for Plastic Surgery
Plastic Surgery

Medical History

Date ___/____/____

Patient Name _____ **Patient Date of Birth** ____/____/____

Note: If you have already used our online Patient Portal, please start on page 3 at Social History.

Who Referred You? _____

Primary Care Physician (PCP) _____ **PCP Phone** _____

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

None
Arthritis
COPD
Depression
Diabetes mellitus
End-stage kidney disease
Hypertension
HIV infection
High cholesterol
Leukemia
Lymphoma
Cancer of colon
Sleep apnea
Admit to psychiatric day hospital
Adrenal cortical hypofunction
Anxiety disorder
Asthma
Atrial fibrillation
Autoimmune disease
Benign enlargement of prostate
Bipolar disorder
Blood coagulation disorder
Breastfeeding
Cerebral trauma
Stroke
Coronary heart disease
Deep vein thrombosis
Adverse anesthesia outcome
Easy bruising
Elevated blood pressure
Epilepsy
Functional vision loss
Gastroesophageal reflux disease
Hearing loss
Heart valve disorder
Hyperthyroidism
Hypothyroidism
Hepatitis
Kidney disease
Lupus
Transplant
Breast cancer
Lung cancer
Cancer of prostate
Neuromuscular junction disorder
Paralysis
Pneumothorax
Pregnant
Pulmonary embolism
Radiation therapy treat. mgmt.
Rheumatoid arthritis (gout)
Seizure
Substance abuse
Thalassemia
Traumatic injury

Other _____

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

None

History of colectomy
Abdominoperineal resection
Bilateral replacement of knee joints
Biopsy of breast
Biopsy of prostate
Classical cesarian section
Complete excision of lung (L / R)
Coronary artery bypass graft
Entire transplanted kidney
Excision of basal cell carcinoma
Excision of melanoma
Excision of middle lobe of right lung
Excision of squamous cell carcinoma
Gastrostomy
History of (H/O:) spinal surgery
H/O: colostomy
H/O: tubal ligation
H/O: appendectomy
H/O: bilateral mastectomy
H/O: cholecystectomy
H/O: esophagectomy
H/O: liver excision
H/O: ... transluminal coronary angioplasty
H/O: tissue graft heart valve replacement
H/O: removal of urinary bladder
H/O: transurethral resection of prostate
Hysterectomy
Kidney biopsy
Laparoscopy
Laparotomy
Lobectomy of lower lobe of lung (L / R)
Lobectomy of upper lobe of lung (L / R)
Low anterior resection of rectum
Lumpectomy of breast (L / R)
Mastectomy of breast (L / R)
Mechanical heart valve replacement
Excision of ovary
Operation on brain
Excision of pancreas
Percutaneous extraction of kidney stone with fragmentation Liver shunting operation
Prostate excision
Bilateral replacement of hip joints
Repair of femoral hernia
Repair of umbilical hernia
Repair of ventral hernia
Small intestine excision
Splenectomy
Surgical biopsy of skin
Total gastrectomy
Nephrectomy (kidney excision)
Orchidectomy
Total replacement of hip joint (L / R)
Total replacement of knee joint (L / R)
Total resection of visible brain tumor
Heart transplant
Liver transplant

Other _____

Plastic Surgery History *(If you are seeing Dr. Gowen at CCPS, please circle all that apply)*

None

Abdominoplasty
Abdominoplasty and liposuction
Augmentation of chin
Breast augmentation
Bilateral blepharoplasty of lower eyelids
Bilateral blepharoplasty of upper eyelids
Browlift
Burn care management
Cheek operation
Chemical peel of skin
Body contouring
Circumferential lipectomy
Correction of inverted nipples
Decompression of ulnar nerve at elbow
Dermabrasion
Extensive blepharoplasty
Facial paralysis surgery
Face lift
Mastopexy
Fracture of frontal sinus
Grafting to skin
Hair transplant
H/O: carpel tunnel decompression
Internal fixation of bone of phalanges of hand
Laser removal of hair
Laser resurfacing of skin
Breast reconstruction
Modification of cranioplasty
Nasal septoplasty
Nipple reconstruction
Open reduction of fracture with internal fixation
Orthopedic hardware in situ
Osteotomy of maxilla
Plastic surgery
Pressure ulcer care management
Procedure on ganglion cyst
Procedure on metacarpal bone
Reconstruction of ear
Reconstruction of nose
Reconstruction of zygoma
Reconstruction of otoplasty of cartilage of ear
Reconstruction procedure
Reconstruction with local flap
Breast reduction, bilateral Reduction of blow-out fracture of orbital floor Reduction of fracture of facial bone
Reduction of fracture of jaw
Reduction of fracture of maxilla
Release of trigger finger
Removal of implant
Repair of abdominal wall
Repair of cleft lip
Repair of cleft palate
Repair of ear lobe
Repair of extensor tendon forearm, wrist, hand
Repair of flexor tendon forearm, wrist, hand
Repair of mallet finger
Revision of scar
Surgical procedure on soft tissue
Sutural craniectomy
Thigh reduction
Transfer of tendon
Wrist repair

Other _____

Plastic Surgery History – Addition Sections *(If you are seeing Dr. Gowen at CCPS, please circle all that apply)*

Family History of Breast Cancer? Yes No
Family History of Malignant Hyperthermia and Anesthesia Sensitivity? Yes No
Herbal Medications and Supplements? Yes No
If Yes, please list: _____

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

None

Acne
Actinic keratosis
Asteatosis cutis
Basal cell carcinoma of skin
Contact dermatitis due to poison ivy
Atypical nevus of skin
Eczema
H/O: Asthma
H/O: hay fever
Malignant melanoma
Pruritus of Scalp
Psoriasis
Squamous cell carcinoma
Sunburn of second degree

Other _____

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

Family History of Skin Cancer _____ Melanoma _____ Squamous Cell _____ Basal Cell ____ None
If yes, which relative(s)? _____

Date ___/____/____

Patient Name _____ **Patient Date of Birth** ____/____/____

CURRENT MEDICATIONS: Dosage, Frequency and Route *(include vitamins, herbal and over-the-counter products)*

MEDICATION	DOSE (mg, mL, puff, cc, patch, etc)	Frequency (once a day, twice a day, as needed)	ROUTE (by mouth, on skin, in eye, etc)
Example: *Aspirin*	*81mg*	*Daily*	*By Mouth*

******PLEASE CONTINUE MEDICATION LIST ON A SECOND SHEET, IF NEEDED******

Preferred Pharmacy _____ **Phone** (_____)_____

Pharmacy Address _____
_____

Allergies *(Please enter all allergies)* _____
_____

Height_____ **Weight**_____

Social History *(Please check all that apply)*

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

Alcohol Use ____ None ____ Less than 1 drink daily ____ 1-2 drinks per day ___ 3 or more daily

Drug Use ____ Yes ____ No ____ Prefer not to answer

History of high blood pressure in your family? Yes No *(Please circle Yes or No)*
If Yes, who? _____

Are you pregnant or nursing? Yes No Other

Do you have a living will? Yes No
If Yes, who is your Healthcare Proxy? _____

Did you receive the COVID-19 vaccine? Yes No
____Moderna ____Pfizer ____Johnson & Johnson How many doses did you receive? ____

Did you receive a Flu vaccine this year? Yes No Other

Did you receive a Pneumonia vaccine? Yes No Other

Did you receive a Shingles vaccine? Yes No Other

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

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

Other Symptoms: _____

_____

Alerts: Are you currently experiencing any of the following? (*Please circle Yes or No)*

• **History of melanoma (if yes, where?)**	**Yes**	**No**
• **Family history of melanoma (if yes, who)?**	**Yes**	**No**
• **History of fainting / vasovagal episode**	**Yes**	**No**
• **History of breast cancer**	**Yes**	**No**
• **Family history of breast cancer (if yes, who)?**	**Yes**	**No**
• **Allergy to adhesive**	**Yes**	**No**
• **Allergy to betadine/ shellfish**	**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**
• **Defibrillator**	**Yes**	**No**
• **Hepatitis C**	**Yes**	**No**
• **HIV / AIDs**	**Yes**	**No**
• **MRSA** (methicillin resistant staph aureus**)**	**Yes**	**No**
• **Pacemaker**	**Yes**	**No**
• **Pregnancy or planning a pregnancy**	**Yes**	**No**
• **Premedication prior to procedures**	**Yes**	**No**
• **Rapid heartbeat with epinephrine**	**Yes**	**No**