BRYN MAWR
SKIN & CANCER
INSTITUTE

Medical Dermatology
CIRILLO INSTITUTE

Medical History

Please complete front & back - 3 pages.

Date ___/____/____

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

Note: If you have already used our online Patient Portal, please start on page 2 at Social History.

Primary Care Physician ____

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	
	Hay fever Allergies	Leukemia	
Breast Cancer	Hearing Loss	Lung Cancer	None

Other ____

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

Appendix Removed	Lumpectomy (Right, Left, Bilateral)
Bladder Removed	Breast Biopsy (Right, Left, Bilateral)
Mastectomy (Right, Left, Bilateral)	Breast Reduction
Breast Implants	Kidney Stone Removal
Colectomy: Colon Cancer Resection	Ovaries Removed: Endometriosis
Colectomy: Diverticulitis	Ovaries Removed: Cyst
Colectomy: IBD (inflammatory bowel disease)	Ovaries Removed: Ovarian Cancer
Gallbladder Removed	Prostate Removed: Prostate Cancer
Coronary Artery Bypass	Prostate Biopsy
PTCA (Coronary Angioplasty)	TURP (transurethral resection of prostate)
Mechanical Valve Replacement	Spleen Removed
Biological Valve Replacement	Testicles Removed (Right, Left, Bilateral)
Joint Replacement, Knee (Right, Left, Bilateral)	Hysterectomy: Fibroids
Joint Replacement, Hip (Right, Left, Bilateral)	Hysterectomy: Uterine Cancer
Kidney Biopsy	None
Kidney Removed (Right, Left)	Other ______________________________

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

Acne	Dry Skin	Melanoma	None
Actinic Keratoses	Eczema	Poison Ivy	Other: ____________
Asthma	Flaking or Itchy Scalp	Atypical Moles (nevi)	
Basal Cell Skin Cancer	Hay Fever / Allergies	Psoriasis	
Blistering Sunburns	Keloid Scarring	Squamous Cell Skin Cancer	

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)? ____

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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)* ________________________________

____

____

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 currently 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

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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: ____

____

____

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

• **History of melanoma**	**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**

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