BRYN MAWR SKIN & CANCER INSTITUTE

Medical Dermatology
CIRILLO INSTITUTE

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.

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation (irregular heartbeat)
BPH (benign prostatic hyperplasia)
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD (chronic obstructive pulmonary disease)
Coronary Artery Disease
Depression
Defibrillator
Diabetes
End Stage Renal Disease
GERD (gastroesophageal reflux disease)
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement

None

Other _____

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

Other _____

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Skin Disease History: (Please circle all that apply)

Acne	Hay Fever / Allergies
Actinic Keratoses	Melanoma
Asthma	Poison Ivy
Basal Cell Skin Cancer	Precancerous Moles (atypical)
Blistering Sunburns	Psoriasis
Dry Skin	Squamous Cell Skin Cancer
Eczema	
Flaking or Itchy Scalp	None

Other _____

Do you wear Sunscreen? Yes No

If yes, what SPF? _____

Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No

If yes, which relative(s)? _____

Any other family history of Skin Cancer? _____

Medications: (Please enter all current medications, or attach a list)

_____
_____
_____

Preferred Pharmacy: _____ **Phone:** _____

Pharmacy Address: _____
_____
_____

Allergies: (Please enter all allergies)

_____
_____
_____

Social History: (Please circle all that apply)

Tobacco Smoking:

- Never smoked
- Quit: former smoker
- Smoke less than daily
- Smoke daily

History of high blood pressure in your family? Yes No

If yes, who? _____

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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____

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 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**

Other Alerts: _____