



# Medical History

Please complete front & back - 3 pages.

Date \_\_\_/\_\_\_/\_\_\_

Medical Dermatology  
CIRILLO INSTITUTE

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       |                         |
| Breast Cancer          | Hay fever Allergies     | Leukemia             |                         |
| Other _____            | Hearing Loss            | Lung Cancer          | None                    |

**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 | Precancerous Moles (atypical) |              |
| 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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Date \_\_\_/\_\_\_/\_\_\_

Patient Name \_\_\_\_\_ Patient Date of Birth \_\_\_/\_\_\_/\_\_\_

**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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