Patient Medical Form

GREELEY DERMATOLOGY & SKIN CANCER CENTER

Personal Identification

Title:______First:______________________________Middle:________________Last:_________________________

Nickname:____________________________ Former Name:_________________________

Date of Birth: _________________________________Age: __________Gender: ______________________________

Section I: Past Medical History (Please circle ALL that may apply and add any not listed)

Anxiety	Depression	Leukemia
Arthritis	Diabetes	Lung Cancer
Asthma	End Stage Renal Disease	Lymphoma
Atrial Fibrillation	GERD	Melanoma
Bone Marrow Transplant	Hearing Loss	Melanoma-Family History
Breast Cancer	Hepatitis	Prostate Cancer
Colon Cancer	High Blood Pressure	Skin Cancer (Other)
COPD	High Cholesterol	Stroke
Coronary Artery Disease	HIV/AIDS	***NONE***

List all major surgeries: ____

Do you require antibiotics prior to a surgical procedure? YES NO

Section IV: Social History

1. Are you a current or past smoker? No Yes
2. If yes, how much? _________________________________

Section V: Medications

Are you taking any medications, vitamins or herbal supplements? ☐ No ☐ Yes, please list:

Name: ______________________________________ Reason: ____

Name: ______________________________________ Reason: ____

Name: ______________________________________ Reason: ____

Name: ______________________________________ Reason: ____

Name: ______________________________________ Reason: ____

Section VI: Allergies and Sensitivities

Are you allergic to any medications or local anesthesia? ☐ No ☐ Yes, please list:

____

____

Section VII: Alerts: (Please circle ALL that may apply and add any not listed)

Allergy to Adhesive	Artificial Heart Valve	Defibrillator
Allergy to Lidocaine	Artificial Joint Replacement	MRSA
Allergy to Topical Antibiotics	Blood Thinners	Pacemaker
		NONE

Do you have a rapid heart beat with epinephrine? YES NO

Are you pregnant or currently trying to get pregnant? YES NO

I have read this questionnaire and disclosed my medical history to the best of my knowledge.

Patient Signature:___________________________________ **Date:** _____________