

CENTRAL CAROLINA DERMATOLOGY CLINIC, INC.
PATIENT HEALTH INFORMATION

NAME: _____ **AGE:** _____ **SEX:** M or F **DATE:** _____

1) Please circle if you have ever had or have any of these diagnoses / problems and give details.

Skin Cancer – BCC, SCC, Melanoma _____

Other Cancers – please specify _____

Artificial Heart Valve or Artificial Joint? When was it placed? _____

Heart Murmur that requires antibiotics for dental work? _____

Pacemaker or Defibrillator? When was it placed? _____

Autoimmune disease - lupus, rheumatoid arthritis, crohn's disease, other _____

Infectious Diseases – HIV, Hepatitis B, Hepatitis C, Tuberculosis, other _____

Blood Clots – DVT (deep venous thrombosis), PE (pulmonary embolus), other _____

Keloid (Thick) Scarring

Thyroid Disease

High Blood Pressure

Kidney disease

Diabetes

Stroke

Bleeding problems

Lung Disease/Asthma/ Emphysema

Heart disease

Hepatitis / liver disease

Seizures / Epilepsy

Severe Memory Problems/ Dementia

Blood transfusion

2) Do any of your first degree relatives (mother, father, siblings, children) have melanoma or other skin cancers? If so, specify _____

3) Circle any blood thinning medicines you take. Coumadin, Plavix, Lovanox, Aspirin? List why you need them. _____

4) For females. Are you presently pregnant, planning a pregnancy or breastfeeding?

5) Do you smoke or chew tobacco? If so, about how much per week? _____

6) Do you drink alcohol? If so, about how much per day? _____

7) Please list all operations/surgeries you have had with approximate date: _____

8) Please list all medications you are currently taking, including over the counter ones: _____

9) Please list known medical allergies, including latex. _____

10) Is there anything about your health that we didn't ask, but need to know? _____
