SKIN and CANCER CENTER of Arizona

An Established Tradition of Medical Excellence

PATIENT NAME: _____ **DOB:** _____

PAST MEDICAL HISTORY

Select any of the following medical conditions that you currently have:

❒NONE

□ Anxiety
□ Arthritis
□ Asthma
□ Atrial Fibrillation (Irregular Heartbeat)
□ Bone Marrow Transplantation
□ Benign Prostatic Hyperplasia
□ Breast Cancer
□ Colon Cancer
□ COPD
□ Coronary Artery Disease
□ Depression
□ Diabetes
□ End Stage Renal Disease
□ GERD
□ Hearing Loss
□ Hepatitis
□ Hypertension
□ HIV / AIDS
□ Hypercholesterolemia
□ Hypothyroidism
□ Leukemia
□ Lung Cancer
□ Lymphoma
□ Prostate Cancer
□ Radiation Treatment
□ Seizures
□ Stroke
□ Other
_____
_____
_____

PAST SURGERIES

Have you had any surgeries on the following organs?

APPENDIX: □ Appendix (Appendectomy)

BLADDER: □ Bladder (Cystectomy)

BREAST: □ Breast Biopsy □ Lumpectomy (Both Breasts) □ Lumpectomy (L breast) □ Lumpectomy (R breast) □ Lumpectomy (Both breasts) □ Mastectomy (Both breasts) □ Mastectomy (L breast) □ Mastectomy (R breast)

COLON: □ Colon Cancer Resection □ Diverticulitis □ Inflammatory Bowel Disease □ Colostomy □ Gallbladder (Cholecystectomy)

HEART: □ Biological Valve Replacement □ Coronary Artery: Bypass Surgery □ Heart Transplant □ Mechanical Valve Replacement □ PTCA

JOINT REPLACEMENT: □ Hip (Both) □ Hip (L) □ Hip (R) □ Knee (both) □ Knee (L) □ Knee (R)

KIDNEY: □ Kidney Biopsy □ Kidney Stone Removal □ Kidney Transplant □ Nephrectomy

LIVER: □ Hepatectomy □ Liver Transplant □ Shunt

OVARIES: □ Endometriosis □ Ovarian Cancer □ Ovarian Cyst □ Tubal Ligation

PANCREAS: □ Pancreatectomy

PROSTATE: □ Prostate Biopsy □ Prostate Cancer □ Benign Prostatic Hyperplasia □TURP

RECTUM: □ APR □ Low Anterior Resection

SKIN: □ Basal Cell Carcinoma □ Melanoma □ Skin Biopsy □ Squamous Cell Carcinoma

SPLEEN (Splenectomy) □

TESTICLES (Orchiectomy) □

UTERUS (Hysterectomy): □ Fibroids □ Uterine Cancer □ Cervical Cancer

OTHER: _____

_____

SKIN DISEASE HISTORY

Have you had any of the following skin conditions?

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

Do you wear sunscreen?

□ YES □ NO

If yes, what SPF? _____

Do you tan in a tanning salon?

□ YES □ NO

FAMILY HISTORY

1. Do you have a family history of Melanoma?
   □ YES □ NO

2. If YES, which relative?
   □ Mother
   □ Father
   □ Sister
   □ Brother
   □ Daughter
   □ Son
   □ Uncle
   □ Other _____
   □ Aunt
   □ Nephew
   □ Niece
   □ Grandmother
   □ Grandfather
   □ Grandson
   □ Granddaughter

□NONE

PHARMACY

Name of Pharmacy _____ Cross Streets _____

City _____ State _____ Phone _____

MEDICATIONS

Prescription and Non-Prescription

Name of Medication(s)	Dosage	Frequency	Route of Administration
1.			**□ Oral □ Topical □ Other :**
2.			**□ Oral □ Topical □ Other :**
3.			**□ Oral □ Topical □ Other :**
4.			**□ Oral □ Topical □ Other :**
5.			**□ Oral □ Topical □ Other :**
6.			**□ Oral □ Topical □ Other :**
7.			**□ Oral □ Topical □ Other :**
8.			**□ Oral □ Topical □ Other :**
9.			**□ Oral □ Topical □ Other :**
10.			**□ Oral □ Topical □ Other :**

ALLERGIES

□ No Known Drug Allergies

Are you allergic to any medications? □ YES □ NO

If yes please specify_____

Describe reaction_____

Severity of reaction: □ Mild □ Mild to Moderate □ Moderate □ Moderate to Severe □ Severe □ Fatal

Other Allergies

_____

_____

SOCIAL HISTORY

□ Unspecified
□ Current every day smoker
□ Current some day smoker (tobacco)
□ Current some day smoker (cigarette)
□ Former smoker
□ Never smoker
□ Smoker, current status unknown
□ Unknown if ever smoked
□ Heavy tobacco smoker
□ Light tobacco smoker

Social History Details

□ Not sexually active
□ Sexually active with one partner
□ Sexually active with more than one partner
□ Same sex partner
□ Drug use
□ IV Drug Use
□ Other _____

□ Alcohol-none
□ Alcohol-less than 1 drink per day
□ Alcohol-1-2 drinks per day
□ Alcohol-3 or more drinks per day
□ Patient feels safe at home
□ Patient feels unsafe at home

Driving Status

□ Drives in the Daytime □ Drives at Night

How often do you exercise?

□ Unspecified □ Several times a day
□ Once a day □ A few times a week
□ A few times a month □ Never
□ Other _____

What is your caffeine use?

□ Unspecified □ Several times a day
□ Once a day □ A few times a week
□ A few times a month □ Never
□ Other _____

Occupation and Workplace

_____
_____
_____

Place of Residence

□ House □ Apartment □ Condo □ Other _____

FAMILY HISTORY

Add New Family History

_____
_____
_____

Other Family Histories

_____
_____
_____