

NEW PATIENT HEALTH INFORMATION

Name _____

Date of Birth _____ Age _____ Today's Date _____

Have you ever been diagnosed with:

Yes No SKIN CANCER - BASAL CELL CARCINOMA, SQUAMOUS CELL CARCINOMA, MELANOMA

If YES, please describe the type of skin cancer, location, treatment and date.

Yes No FAMILY HISTORY OF MELANOMA

Yes No Do you smoke? _____ pp day

Yes No Do you use alcohol? _____ How much

Do you have or have you had:

Yes No ARTIFICIAL JOINT/ Site _____ Date _____

Yes No CANCER Type _____

Yes No HEPATITIS Type _____ When Diagnosed _____

Yes No POSITIVE HIV Yes No HIGH CHOLESTEROL

Yes No BLEEDING PROBLEMS Yes No KELOIDS/THICK SCARS

Yes No HEART PROBLEMS Yes No STROKE

Yes No HEART MURMUR/MVP Yes No SEIZURES

Yes No PROSTHETIC HEART VALVE LAST SEIZURE _____

Yes No PACEMAKER/DEFIBRILATOR Yes No HISTORY OF TUBERCULOSIS

Yes No ARRHYTHMIA Yes No DIABETES

Yes No ARE YOU PREGNANT Yes No NEUROPATHY

Yes No OR BREASTFEEDING? Yes No HORMONE REPLACEMENT

Yes No THYROID PROBLEM THERAPY

Yes No HIGH BLOOD PRESSURE Yes No OTHER _____

Yes No ARTHRITIS

Yes No ALLERGIC TO ANY MEDICATIONS?

Please List _____

PLEASE LIST MEDICATIONS AND DOSAGES

1. _____	10. _____
2. _____	11. _____
3. _____	12. _____
4. _____	13. _____
5. _____	14. _____
6. _____	15. _____
7. _____	16. _____
8. _____	17. _____
9. _____	18. _____

SKIN CANCER CENTER OF CENTRAL FLORIDA

www.skincancersurgery.net