Skin & Laser Surgery Center, P.C.

Dermatology, Laser, Cosmetic & Mohs Skin Cancer Surgery

1359 Beverly Rd 2nd Floor Mclean, VA 22101••2200 Opitz Blvd, Suite 100, Woodbridge, VA 22191

Name:_____ Today's Date: (month)_____/(day)_____/(year)_____

MEDICAL HISTORY

What is the reason for your visit today? _____

When did the problem begin? _____

What body locations are involved? _____

Is it associated with: ☐ Bleeding ☐ Itching ☐ Stinging ☐ Other _____

What have you used to the area so far and has it worked? _____

Have you been evaluated by another physician for this problem?_____

PAST MEDICAL HISTORY: (Please Circle ALL that apply)

Anxiety	Diabetes	High Blood Pressure	Psychiatric condition
Arthritis	Kidney Disease	HIV	Peptic ulcer
Asthma	GERD (Acid reflux)	High Cholesterol	Radiation Treatment
Atrial fibrillation	Glaucoma/Cataracts	Hyperthyroidism	Seizures/Epilepsy
COPD (Emphysema)	Heart murmur	Hypothyroidism	Tuberculosis
Coronary Artery Disease	Hearing Loss	Liver disease	Joint Replacement
Depression	Hepatitis A/B/C	Pacemaker/Defibrillator	Stroke
Other_____			**None**

Do you have a history of cancer? Yes / No If so, what type?_____

Have you had any surgical procedures? Yes / No If so, what type and the year that you had them?

_____ _____

_____ _____

SKIN DISEASE HISTORY: (Please Circle ALL that apply)

Acne	Eczema	Precancerous Moles
Actinic Keratosis	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Keloids	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	Cold sores/fever blisters
Dry Skin	Poison Ivy	**None**/Other _____

Do you wear Sunscreen? Yes / No If yes, what SPF? _____Do you tan in a tanning salon? Yes / No

Do you have a family history of skin cancer? Yes / No If yes, what kind? Basal cell, Squamous cell, Melanoma, Other_____

Which relative(s)? _____

Do you have a family history of Vitiligo, Lupus, Psoriasis, or Eczema? Yes / No Which relative(s)? _____

Do you have a family history of Cancer, High Blood Pressure, Diabetes, Heart Disease, Kidney Disease, or Liver Disease?

Yes / No Which relative(s)? _____

REVIEW OF SYSTEMS: (Please Circle ALL that apply)

Problems with healing	Hay fever symptoms	Abdominal pain	Headaches
Problems with scarring	Problems with bleeding	Bloody urine	Seizures
Fever or chills	Blurry vision	Bloody stool	Cough
Night sweats	Sore throat	Joint aches	Wheezing
Unintentional weight loss	Chest pain (right now)	Muscle weakness	**None**

MEDICATIONS: Are you currently on any medications? Yes/No (please circle) If so please enter all current medications including over the counter medications (this includes vitamins, birth control pills, Ginseng, Gingko Biloba, etc.)

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you take antibiotics prior to procedures? Yes / No

ALLERGIES: Yes/No (Please list) _____

SOCIAL HISTORY:

Are you pregnant/ lactating? Yes / No

Date of last menstrual cycle. _____

Do you have a history of **smoking** cigarettes? Yes/No Do you currently smoke? If so, how many packs per day? _____

Do you drink alcohol? Yes / No If so, how frequently? _____

Do you have any pets? Cats, Dogs, Birds, None, Other _____

What is your occupation? _____