Arkansas Skin Cancer
C E N T E R

DERMATOLOGY MEDICAL HISTORY

Patient name:_____ Date: _____

Referring Physician: _____

How long have you had this condition? _____ Weeks / Months / Years

• Has the lesion changed in color?	Yes	No
• Does it bleed?	Yes	No
• Does it itch?	Yes	No
• Has it grown?	Yes	No
• Does it scale or flake?	Yes	No
• Is it painful?	Yes	No
• Has the area been biopsied?	Yes	No
• Has the area been previously treated?	Yes	No
• Do you have a history of skin cancer?	Yes	No
• Do you have a family history of skin cancer?	Yes	No
• Do you have lupus?	Yes	No
• Have you had an organ transplant?	Yes	No
• Have you had a lot of sun exposure?	Yes	No

PLEASE LIST ALL CURRENT MEDICATIONS AND DRUG ALLERGIES IN THE AREA PROVIDED BELOW. PLEASE INCLUDE ALL OVER THE COUNTER MEDICINE, VITAMINS, AND HERBAL THERAPIES.

Drug Allergies: _____

Medications: _____

_____

_____

_____

PLEASE COMPLETE THE INFORMATION ON THE BACK OF THIS FORM

DERMATOLOGY REVIEW OF SYSTEMS

Heart Failure	**Yes**	**No**	Heart Attack	**Yes**	**No**
Stent Placement	**Yes**	**No**	Bypass	**Yes**	**No**
Mitral Valve Prolapse	**Yes**	**No**	Murmur	**Yes**	**No**
Artificial Heart Valve	**Yes**	**No**	Pacemaker	**Yes**	**No**
High Blood Pressure	**Yes**	**No**	Defibrillator	**Yes**	**No**
Rheumatic Fever	**Yes**	**No**	Angina Pectoris	**Yes**	**No**
Stroke	**Yes**	**No**	Anemia	**Yes**	**No**
Emphysema	**Yes**	**No**	Cough	**Yes**	**No**
Tuberculosis	**Yes**	**No**	Sinus Trouble	**Yes**	**No**
Allergies	**Yes**	**No**			
Dizziness	**Yes**	**No**	Headaches	**Yes**	**No**
Anxiety	**Yes**	**No**	Nervousness	**Yes**	**No**
Depression	**Yes**	**No**			
Arthritis	**Yes**	**No**	Artificial Joints	**Yes**	**No**
Rheumatism	**Yes**	**No**			
Glaucoma	**Yes**	**No**	Cataracts	**Yes**	**No**
Macular Degeneration	**Yes**	**No**			
Indigestion	**Yes**	**No**	Reflux	**Yes**	**No**
Ulcers	**Yes**	**No**			
Diabetes	**Yes**	**No**	HIV	**Yes**	**No**
Hepatitis	**Yes**	**No**	Liver Disease	**Yes**	**No**
Thyroid Disease	**Yes**	**No**	Staph Infection	**Yes**	**No**

Other Medical Conditions: _____

SOCIAL HISTORY

Do you consume alcohol?	**Yes**	**No**
Do you consume caffeine?	**Yes**	**No**
Do you use tobacco?	**Yes**	**No**

PLEASE COMPLETE THE INFORMATION ON THE FRONT OF THIS FORM