

BALDONE REINA DERMATOLOGY, APMC

General and Cosmetic Dermatology
Mohs' Micrographic Surgery

Please be complete and honest. This information is strictly confidential and used only to evaluate and treat your medical condition.

Patient's name _____ Date _____
Age _____ Sex _____

Reason for appointment _____

Referring Physician _____ Primary Physician _____

General Health: Please Circle Excellent Good Fair Poor

Past Medical History: Have you ever had or do you currently have any of the following medical conditions? Check all that apply

- | | | |
|--|---|--|
| <input type="checkbox"/> Hypertension
(high blood pressure) | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Melanoma |
| <input type="checkbox"/> Migraines/
Chronic headaches | <input type="checkbox"/> Arthritis | <input type="checkbox"/> other Skin Cancer
Type _____ |
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Other Cancer
Type _____ |
| <input type="checkbox"/> Seizures/Epilepsy | <input type="checkbox"/> Excessive scarring
or Keloids | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Poor Healing | <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Mental disorder
Type _____ | <input type="checkbox"/> Heart Valve
Replacement |
| <input type="checkbox"/> Heart Disease
Type _____ | <input type="checkbox"/> Asthma | <input type="checkbox"/> Medical
condition not listed |
| <input type="checkbox"/> Connective tissue disease | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Type _____ |
| <input type="checkbox"/> Urticaria/ Hives | <input type="checkbox"/> Anemia | |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Hepatitis | |

How does your skin respond to sun exposure? Always burn, never tan Always burn, sometimes tan
 Sometimes burn, always tan Never burn, always tan

Female Patients: Date of last menstrual cycle _____ Are you currently pregnant or could you be pregnant? _____
Type of birth control _____ Previous pregnancies _____

Past surgeries or hospitalizations _____

Occupation _____

Social history: Do you smoke? yes no Alcohol Use: Please Circle None Occasionally Frequently Daily
Drug Use: yes no Type _____

Medications: (Please include any over the counter medications, supplements, as well as prescription drugs)

Drug Allergies: _____

Family history of Melanoma or other types of skin cancer: yes no

I hereby declare that I have honestly and completely answered the above questions to the best of my knowledge. I understand that it is my obligation and responsibility to notify Baldone • Reina Dermatology, APMC of any changes in my medical condition or medications during the course of my medical treatment or at follow up visits.

Signed: _____ Date: _____