**Patient History Form**

**Name_____ Date of Birth _____**

Ethnic Group – Hispanic or Latino Not Hispanic or Latino
Race _____
Preferred Language _____

**Patient Past Medical History**

| Do you have a history of: | | |
|---|---|---|
| Cancer (other than skin) | Yes | No |
| Diabetes | Yes | No |
| Gastrointestinal Illness | Yes | No |
| Hepatitis/HIV | Yes | No |
| Pacemaker/defibrillator | Yes | No |
| Thyroid Disorder | Yes | No |
| Tuberculosis | Yes | No |

**History of Skin Cancer**

| | | |
|---|---|---|
| Personal history of skin cancer | Yes | No |
| Personal history of melanoma | Yes | No |
| Family history of skin cancer or melanoma | Yes | No |
| Have you ever used a tanning bed? | Yes | No |
| Do you wear sunscreen consistently? | Yes | No |

**Allergies**

| Do you have any allergies or reactions to: | | |
|---|---|---|
| Rubber/latex | Yes | No |
| Eggs (allergy) | Yes | No |
| Milk (allergy) | Yes | No |
| Local anesthetics (ex: Lidocaine) | Yes | No |
| Epinephrine | Yes | No |
| Topical antibiotics (ex: Neosporin) | Yes | No |
| Surgical Tape/bandages | Yes | No |

**Family Medical History**

| Adopted | | |
|---|---|---|
| Arthritis | Yes | No |
| Autoimmune disorder | Yes | No |
| Diabetes | Yes | No |
| Hayfever, asthma, allergies | Yes | No |

**Surgical History – Past Major Surgeries (Include Cosmetic Procedures)**

Skin cancer surgery _____-

Plastic Surgery_____

**Social History (please circle appropriate answer )**

Smoking Status
Non-Smoker
Current Smoker
Former Smoker