

# THE DERMATOLOGY AND SKIN CANCER CLINIC OF ALASKA, P.C.

Patient \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_ Chart # \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

Have you ever had dental anesthesia (Novocain)?  Yes  No Any bad reaction?  Yes  No

List all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins, & herbs):

1. \_\_\_\_\_ 3. \_\_\_\_\_ 5. \_\_\_\_\_  
 2. \_\_\_\_\_ 4. \_\_\_\_\_ 6. \_\_\_\_\_

List all known allergies (including prescriptions, over-the counter meds, plastic and/or adhesives)

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

Do you have or have you ever had any of the following diseases or conditions: (Please check YES or NO)

<b>Lungs:</b>	<b>YES</b>	<b>NO</b>	<b>Gastrointestinal:</b>	<b>YES</b>	<b>NO</b>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	<b>Other Systemic:</b>	<b>YES</b>	<b>NO</b>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>

<b>Cardiovascular:</b>	<b>YES</b>	<b>NO</b>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>
Inflammation of Vein	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>
<b>Artificial Joints</b>	<input type="checkbox"/>	<input type="checkbox"/>

Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Frequency/Burning	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Nausea, vomiting, diarrhea when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Yeast infection when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
<b>Neurological:</b>	<b>YES</b>	<b>NO</b>
Stroke/TIA	<input type="checkbox"/>	<input type="checkbox"/>
Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>
<b>Cancer (other than skin)</b>	<input type="checkbox"/>	<input type="checkbox"/>

Location/Age of Joint: \_\_\_\_\_

List any other diseases or conditions: \_\_\_\_\_

List any surgical procedures that you have had in the last 6 months: \_\_\_\_\_

Have you ever been advised to take antibiotics before surgery?  YES  NO

If yes, why? \_\_\_\_\_ Which antibiotic? \_\_\_\_\_

Do you take any blood thinners? (aspirin, vit E, coumadin or any other prescription blood thinner)  YES  NO

If yes: \_\_\_\_\_

**Skin**

Have you ever had skin cancer?  YES  NO

If yes what type \_\_\_\_\_ Location \_\_\_\_\_ Treatment given \_\_\_\_\_

- Has anyone in your family had skin cancer?  YES  NO
- Do you have a history of any specific skin disease?  YES  NO
- Do you have problems with healing?  YES  NO
- Do you develop keloids (scars) after surgery?  YES  NO
- Do you bleed easily?  YES  NO
- Do you develop skin rashes in reaction to  Medications  Food  Environment? \_\_\_\_\_

**Social History:**

Do you drink alcohol?  YES  NO If yes, how many drinks per day? \_\_\_\_\_

Do you/have you used IV drugs?  YES  NO If yes, what? \_\_\_\_\_ How often? \_\_\_\_\_

Do you smoke?  YES  NO If yes, how much? \_\_\_\_\_

Do you have or have you been exposed to HIV (AIDS)?  YES  NO

What is your occupation? \_\_\_\_\_ Hobbies? \_\_\_\_\_

(Women) Are you pregnant?  YES  NO Due Date: \_\_\_/\_\_\_/\_\_\_

Completed by: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_ MA Initials \_\_\_\_\_