THE DERMATOLOGY AND SKIN CANCER CLINIC OF ALASKA

180 E. Beluga Ave. Soldotna, Alaska 99669

Mathew M. Cannava, M.D.

Legal Patient Name (LAST, FIRST, MI)

Date of Birth: **Todays Date:**

Reason for today's visit:

Primary Care Physician:

Preferred Pharmacy:

**** If you have a private insurance (not Medicare or Medicaid), what is your method of payment for today? (check one):**

☐ Cash or ☐ Credit/Debit Card (Visa, Mastercard, AmericanExpress, etc.)

Current medications (including prescriptions, over-the-counter meds, blood thinners, vitamins, & herbs):

_____

Allergies (including prescriptions, over-the-counter-meds, plastic and/or adhesives):

_____

Have you ever had a bad reaction to dental anesthesia (Novocaine/ Lidocaine)?:

☐ Yes ☐ No

If yes, what was the reaction? _____

Please indicate all that apply to you, now or in the past:

Lungs:

- ☐ Bronchitis
- ☐ Emphysema
- ☐ Asthma
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Chronic Cough

Cardiovascular:

- ☐ High Blood Pressure
- ☐ Chest Pain
- ☐ Heart Attack
- ☐ Irregular Heart Beat
- ☐ Heart Murmur
- ☐ Inflammation of Vein
- ☐ Blood Clots
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Artificial Heart Valve

Artificial Joints:

- ☐ Location/Yr. of replacement:_____

Gastrointestinal:

- ☐ Hepatitis
- ☐ Liver Disease
- ☐ Diabetes

Other Systemic:

- ☐ Thyroid
- ☐ Kidney
- ☐ Bladder
- ☐ Frequency/Burning
- ☐ Arthritis/Joint Deformity
- ☐ Fainting, Nausea, Vomiting, Diarrhea- When taking antibiotics
- ☐ Yeast Infection- When taking antibiotics

Neurological:

- ☐ Stroke/TIA
- ☐ Seizure Disorder

Cancer (other than skin):

- ☐ Location: _____

Other diseases or conditions: _____

List any surgical procedures that you have had in the past 6 months:

_____

If you have ever been advised to take an antibiotic before surgery, list why and which antibiotic:

_____

Social History:

Do you drink alcohol? ☐ **Yes** ☐ **No**

If yes, how many drinks per day?:

Do you/have you used recreational drugs? ☐ **Yes** ☐ **No**

If yes, what? _____ How often? _____

Do you smoke cigarettes? ☐ **Yes** ☐ **No**

If yes, how much?

Do you or have you been exposed to HIV (AIDS)? ☐**Yes** ☐**No**

(Women) Are you pregnant? ☐ **Yes** ☐ **No**

If yes, due date:

Skin:

Have you ever had skin cancer? ☐ **Yes** ☐ **No**

If yes:

Type _____ **Location** _____ **Treatment**_____

Has anyone in your family ever 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? (That don't heal)

☐ **Yes** ☐ **No**

Do you bleed easily for any reason?

☐ **Yes** ☐ **No**

Occupation and/or hobbies: