WESTGATE SKIN & CANCER

PATIENT MEDICAL HISTORY

Blakely Richardson, DO, FAAD
Sital Patel, DO, FAAD
Board-Certified Dermatologist

PAST MEDICAL HISTORY

Check any medical conditions that you currently have:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Irregular Heartbeat
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke

If other, what conditions? ☐ **None**

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List any surgeries that you have ever had:

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast: Biopsy
- ☐ Breast: Lumpectomy (Both)
- ☐ Breast: Lumpectomy (Left)
- ☐ Breast: Lumpectomy (Right)
- ☐ Breast: Mastectomy (Both)
- ☐ Breast: Mastectomy (Left)
- ☐ Breast: Mastectomy (Right)
- ☐ Colon: Colon Cancer Resection
- ☐ Colon: Diverticulitis
- ☐ Colon: Inflammatory Bowel Dis
- ☐ Colon: Colostomy
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Biological Valve Replac
- ☐ Heart: Coronary Bypass
- ☐ Heart: Transplant
- ☐ Heart: Mechanical Valve Repl.
- ☐ Heart: PTCA
- ☐ Joint Replacement: Hip (Both)
- ☐ Joint Replacement: Hip (Left)
- ☐ Joint Replacement: Hip (Right)
- ☐ Joint Replacement: Knee (Both)
- ☐ Joint Replacement: Knee (Left)
- ☐ Joint Replacement: Knee (Left)
- ☐ Kidney: Biopsy
- ☐ Kidney: Stone Removal
- ☐ Kidney: Transplant
- ☐ Kidney: Nephrectomy
- ☐ Liver: Hepatectomy
- ☐ Liver: Transplant
- ☐ Liver: Shunt
- ☐ Ovaries: Endometriosis
- ☐ Ovaries: Cancer
- ☐ Ovaries: Cyst
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate: Biopsy
- ☐ Prostate: Prostatectomy
- ☐ Prostate: TURP
- ☐ Rectum: APR
- ☐ Rectum: Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Biopsy
- ☐ Skin: Squamous Cell Carcin.
- ☐ Spleen (Splenectomy)
- ☐ Testicles (Orchiectomy)
- ☐ Hysterectomy: Fibroids
- ☐ Hysterectomy: Uterine Cancer
- ☐ Hysterectomy: Cervical Cancer
- ☐ **None**

If other, what surgeries?

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SKIN DISEASE HISTORY

Check any skin conditions that you have ever had:

- ☐ Acne
- ☐ Actinic keratoses
- ☐ Asthma
- ☐ Basal cell skin cancer
- ☐ Blistering sunburns
- ☐ Dry skin
- ☐ Eczema
- ☐ Flaking or itchy scalp
- ☐ Hay fever / allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous moles
- ☐ Psoriasis
- ☐ Squamous cell skin cancer

If other, what skin diseases? ☐ **None**

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Do you wear sunscreen? ☐ Yes ☐ No
If yes, what SFP? ____________
Do you tan in a tanning salon? ☐ Yes ☐ No
Do you have a family history of Melanoma? ☐ Yes ☐ No
If yes, who? ______________________

MEDICATIONS

Are you taking any medications? ☐ Yes ☐ No
If yes, what medications? If you have a list, please provide it.

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DRUG ALLERGIES

Do you have drug allergies or reactions? ☐ Yes ☐ No
If yes, what medications? If you have a list, please provide it.

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SOCIAL HISTORY

Check your Smoking Status:

☐ Everyday ☐ Some days ☐ Former Smoker ☐ Never

Check all Social History Details that Currently Apply:

- ☐ Not sexually active
- ☐ 1 Sexual Partner
- ☐ Multiple Sexual Partners
- ☐ Same Sex Partner
- ☐ Drug Use
- ☐ No Alcohol Consumption
- ☐ Less than 1 drink per day
- ☐ 1-2 drinks per day
- ☐ 3 or more drinks per day
- ☐ IV Drug use

FAMILY HISTORY

Check any conditions that run in your family.
First degree relatives only (mother, brother, sister etc.)

- ☐ Arthritis Who? ____________
- ☐ Asthma Who? ____________
- ☐ Psoriasis Who? ____________
- ☐ Cancer Who? ____________
- ☐ Skin Cancer Who? ____________

If yes, what type of skin cancer? ____________
If there is additional family history, what conditions and family which family members?

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CONTACT INFORMATION

OK to leave a Detailed Voicemail? ☐ Yes ☐ No

PHARMACY

Provide the name and intersection or address:
If you don't have a pharmacy or want to support local businesses, we suggest Victory Medical across from Target.

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PRACTICE INFORMATION

Do you have a primary care physician? ☐ Yes ☐ No
If yes, who is the physician?

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Were you referred by a Physician? ☐ Yes ☐ No
If yes, who was the physician, PA, or nurse?

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EDUCATE YOURSELF

Check any areas of interest:
Our practice offers expert cosmetic advice and outstanding aesthetic services by utilizing the latest procedures. Please take a moment to check anything that interests you:

- ☐ Botox Cosmetic
- ☐ Lip Enhancements
- ☐ Neck Rejuvenation
- ☐ Scar Reduction
- ☐ Red/Brown Spots
- ☐ Anti-Aging
- ☐ Chemical Peels
- ☐ Fat Reduction
- ☐ Fillers
- ☐ Facial Redness
- ☐ Neck/Chin Tightening
- ☐ Acne Scarring
- ☐ Sun Damage
- ☐ Spider Vein Treatments
- ☐ Laser Services
- ☐ Skin Elasticity

If other, what cosmetic or aesthetic services interest you?

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REVIEW OF SYSTEMS

Check any situations that apply:

- ☐ Changing Moles/Lesions
- ☐ Itchiness
- ☐ Rash
- ☐ Extreme Fatigue
- ☐ Unintentional Weight Loss
- ☐ Problems with Bleeding
- ☐ Swollen Glands/Lymph Nodes
- ☐ Numbness/Tingling
- ☐ Cough
- ☐ Abdominal Pain
- ☐ Diarrhea
- ☐ Frequent Urination
- ☐ Muscle Weakness
- ☐ Allergy to Adhesive
- ☐ Allergy to Topical Antibiotic
- ☐ Pacemaker/Defibrillator
- ☐ Bone Marrow Transplant
- ☐ Blood Thinner /Daily Aspirin
- ☐ Immunosuppression
- ☐ MRSA (Resistant Staph)
- ☐ Accutane in the 6 months
- ☐ Hair Loss
- ☐ Problems with Scarring
- ☐ Blood Clots
- ☐ Fever/Chills
- ☐ Night Sweats
- ☐ Headaches
- ☐ Insomnia
- ☐ Excessive Thirst
- ☐ Shortness of Breath
- ☐ Bloody Stool
- ☐ Difficulty Swallowing
- ☐ Joint Aches
- ☐ Chest Pain
- ☐ Allergy to Lidocaine
- ☐ Artificial Heart Valve
- ☐ Pregnant or Planning
- ☐ Stomach Ulcers
- ☐ Organ Transplant
- ☐ Hepatitis B or C
- ☐ HIV/AIDS

SIGNATURE

I understand that my signature below confirms that the information on this form is accurate and complete to the best of knowledge.

______________________	______________________	____________	____________
Patient, Guardian, or Responsible Individual Signature	Patient Name	Patient DOB	Date Signed