

Florida Dermatology and Skin Cancer Specialists, PL

Patient Name: _____

Today's Date: _____

Clinical Information

Pharmacy _____ Phone number _____ Address/Side Streets _____

Do you wear Sunscreen? Yes No If, Yes, what SPF: 15 30 45 50 unsure

Do you Tan in a Tanning Salon? Yes No

Do you have a Family history of Melanoma (Skin Cancer)? Yes No If yes, which relatives? _____

Smoking: Never smoked Former Smoker Smoke less than daily Smoke Daily

Allergies (List): _____

Current Medications (include dosage)

Medical History (Check all that apply)

- | | | | |
|--------------------------|--|--------------------------|---|
| <input type="checkbox"/> | Anxiety | <input type="checkbox"/> | Hepatitis |
| <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | Hypertension (High Blood Pressure) |
| <input type="checkbox"/> | Artificial Joints | <input type="checkbox"/> | HIV/AIDS |
| <input type="checkbox"/> | Asthma | <input type="checkbox"/> | Hypercholesterolemia (High Cholesterol) |
| <input type="checkbox"/> | Arterial fibrillation | <input type="checkbox"/> | Hypothyroidism (Overactive thyroid) |
| <input type="checkbox"/> | Benign Prostatic Hyperplasia (Enlarged Prostate) | <input type="checkbox"/> | Hypothyroidism (Underactive thyroid) |
| <input type="checkbox"/> | Bone Marrow Transplantation | <input type="checkbox"/> | Leukemia |
| <input type="checkbox"/> | Breast Cancer | <input type="checkbox"/> | Lung Cancer |
| <input type="checkbox"/> | Colon Cancer | <input type="checkbox"/> | Lymphoma |
| <input type="checkbox"/> | COPD (Emphysema) | <input type="checkbox"/> | Pacemaker |
| <input type="checkbox"/> | Coronary Artery Disease | <input type="checkbox"/> | Prostate Cancer |
| <input type="checkbox"/> | Depression | <input type="checkbox"/> | Radiation Treatment |
| <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | Seizures |
| <input type="checkbox"/> | End Stage Renal Disease | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | GERD (Acid Reflux) | <input type="checkbox"/> | Valve Replacement |
| <input type="checkbox"/> | Hearing Loss | <input type="checkbox"/> | Other: _____ |
| | | <input type="checkbox"/> | None |

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Past Surgical History (Check all that apply)

- | | | | |
|--------------------------|--|--------------------------|--|
| <input type="checkbox"/> | Appendix Removed | <input type="checkbox"/> | Kidney Biopsy |
| <input type="checkbox"/> | Bladder Removed | <input type="checkbox"/> | Kidney Removed ___ Right ___ Left |
| <input type="checkbox"/> | Mastectomy : ___ Right ___ Left ___ Bilateral | <input type="checkbox"/> | Kidney Stone Removal |
| <input type="checkbox"/> | Lumpectomy: ___ Right ___ Left ___ Bilateral | <input type="checkbox"/> | Kidney Transplant |
| <input type="checkbox"/> | Breast Reduction | <input type="checkbox"/> | Ovaries Removed: Endometriosis |
| <input type="checkbox"/> | Breast Implants | <input type="checkbox"/> | Ovaries Removed: Cyst |
| <input type="checkbox"/> | Colectomy: Colon Cancer Resection | <input type="checkbox"/> | Ovaries Removed: Ovarian Cancer |
| <input type="checkbox"/> | Colectomy: Diverticulitis | <input type="checkbox"/> | Prostate Biopsy |
| <input type="checkbox"/> | Colectomy: IBD | <input type="checkbox"/> | TURP (Prostate Resection) |
| <input type="checkbox"/> | Gallbladder Removal | <input type="checkbox"/> | Skin Biopsy |
| <input type="checkbox"/> | Coronary Artery Bypass | <input type="checkbox"/> | Basal Cell Cancer Surgery |
| <input type="checkbox"/> | PTCA (Angioplasty) | <input type="checkbox"/> | Squamous Cell Carcinoma |
| <input type="checkbox"/> | Mechanical Valve Replacement | <input type="checkbox"/> | Melanoma Surgery |
| <input type="checkbox"/> | Biological Valve Replacement | <input type="checkbox"/> | Spleen Removed |
| <input type="checkbox"/> | Heart Replacement | <input type="checkbox"/> | Testicles Removed ___ Right ___ Left ___ Bilateral |
| <input type="checkbox"/> | Joint Replacement Knee ___ Right ___ Left
___ Bilateral | <input type="checkbox"/> | Hysterectomy: Fibroids |
| <input type="checkbox"/> | Joint Replacement Hip ___ Right ___ Left
___ Bilateral | <input type="checkbox"/> | Hysterectomy: Uterine Cancer |
| <input type="checkbox"/> | Joint Replacement within past 2 yrs | <input type="checkbox"/> | No Surgeries |

Skin History

- | | | | |
|--------------------------|-------------------------|--------------------------|---------------------------|
| <input type="checkbox"/> | Acne | <input type="checkbox"/> | Flaking or Itchy Scalp |
| <input type="checkbox"/> | Actinic Keratoses (AKs) | <input type="checkbox"/> | Hay Fever / Allergies |
| <input type="checkbox"/> | Asthma | <input type="checkbox"/> | Melanoma |
| <input type="checkbox"/> | Basal Cell Skin Cancer | <input type="checkbox"/> | Poison Ivy |
| <input type="checkbox"/> | Blistering Sunburns | <input type="checkbox"/> | Precancerous Moles |
| <input type="checkbox"/> | Dry Skin | <input type="checkbox"/> | Psoriasis |
| <input type="checkbox"/> | Eczema | <input type="checkbox"/> | Squamous Cell Skin Cancer |
| <input type="checkbox"/> | | <input type="checkbox"/> | None |