

Medical History

Last Name _____ First Name _____ MI _____ Date _____

**Past Medical History / Review of Systems (Do you currently have or have you ever had any of the following-GIVE DETAILS)
FILL OUT COMPLETELY IN BLACK PEN. IF NO PROBLEMS IN A PARTICULAR SYSTEM, CHECK NORMAL:**

Skin

- None of the below problems
- precancer (actinic keratosis)
- basal cell carcinoma
- squamous cell carcinoma
- melanoma
- abnormal scarring/keloids
- dysplastic moles
- other _____

Musculoskeletal

- Normal
- arthritis
- muscle weakness
- fibromyalgia
- artificial joints
- other _____

Neurological

- Normal
- seizure (epilepsy)
- neuralgia/nerve pain
- numbness/tingling
- stroke
- other _____

Cardiovascular

- Normal
- chest pain
- heart attack
- pacemaker
- heart valve problem
- high blood pressure
- other _____

Respiratory

- Normal
- asthma
- emphysema
- cough
- other _____

Gastrointestinal

- Normal
- stomach ulcer
- colitis
- liver problems
- other _____

Hematologic/Lymphatic

- Normal
- anemia
- bleeding problems
- cancer/enlarged lymph nodes
- other _____

Eye/Ear/Nose/Throat

- Normal
- glaucoma
- hearing aid
- plastic surgery _____
- other _____

Psychiatric

- Normal
- depression
- anxiety
- dementia
- other _____

Endocrine

- Normal
- diabetes
- thyroid
- oral steroid use
- other _____

Infections

- Normal
- hepatitis (circle): A or B or C
- HIV / AIDS
- tuberculosis / TB
- cold sores / other _____

Genitourinary

- Normal
- dialysis
- kidney problems
- venereal disease
- other _____

Allergic/Immunologic

- Normal
- lupus
- organ transplantation
- cancer chemotherapy
- other _____

Constitutional

- Normal
- * Current Weight _____
- fever
- chills
- weight loss

- *Does your dentist ask you to take antibiotics before dental work? Y / N
- *Are you currently pregnant, planning to become pregnant, or nursing? Y / N
- *Are you allergic to latex or rubber? Y / N
- *Have you ever had radiation or UV treatments? Y / N
- *Previous anesthesia complications? Y / N

Surgeries (skin cancer, skin biopsies, and all other surgeries)(If none, state "NONE"): _____

Hospitalizations/Other Illnesses (If none, state "NONE"): _____

Medications: Please list ALL PRESCRIBED MEDICATIONS AND DOSAGES as well as over the counter medications (include birth control pills, aspirin, pain relievers, vitamins, insulin, laxatives, herbal medications, etc) (If none, state "NONE"): _____

[] unable to provide dosage information

Allergies: Please list ALL medication allergies and describe reactions (If none, state "NONE"): _____

**Family History (blood relatives only—list relationship to you):
PLEASE CHECK AND GIVE DETAILS**

- No family history of skin cancer or other skin problems
- Increased number or moles/dysplastic moles _____
- basal cell/squamous cell carcinoma _____
- melanoma _____
- other skin problems _____
- other medical problems _____
- anesthetic complications _____

Social Hx: Do you use sunscreen? _____
How long have you been in AZ? _____
Where did you grow up? _____

Tobacco Use never used tobacco
age started _____ per day _____
age quit _____ or currently using
amount _____ per day / week

Alcohol _____
Occupation/Former Occupation: _____
Did you ever work outside (details)?: _____

Assistant Signature _____ Dr. Michael Huether's Signature _____ Date _____