

Medical History

Last Name _____ First Name _____ MI _____ Date of Birth _____

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:

<u>Skin</u> <input type="checkbox"/> None of the below problems <input type="checkbox"/> precancer (actinic keratosis) <input type="checkbox"/> basal cell carcinoma <input type="checkbox"/> squamous cell carcinoma <input type="checkbox"/> dysplastic moles <input type="checkbox"/> blistering sun burns <input type="checkbox"/> abnormal scarring/keloids <input type="checkbox"/> tanning bed use <input type="checkbox"/> melanoma – date: _____ body location: _____	<u>Musculoskeletal</u> <input type="checkbox"/> Normal <input type="checkbox"/> arthritis <input type="checkbox"/> limb swelling <input type="checkbox"/> fibromyalgia <input type="checkbox"/> artificial joints - R / L hip – date: _____ - R / L knee – date: _____ - other – date: _____	<u>Neurological</u> <input type="checkbox"/> Normal <input type="checkbox"/> seizure / epilepsy <input type="checkbox"/> neuralgia / nerve pain <input type="checkbox"/> numbness / tingling <input type="checkbox"/> stroke or paralysis <input type="checkbox"/> other _____	<u>Cardiovascular</u> <input type="checkbox"/> Normal <input type="checkbox"/> chest pain <input type="checkbox"/> heart attack <input type="checkbox"/> pacemaker <input type="checkbox"/> heart valve problem <input type="checkbox"/> high blood pressure <input type="checkbox"/> irregular heart rate <input type="checkbox"/> other _____
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<u>Respiratory</u> <input type="checkbox"/> Normal <input type="checkbox"/> asthma / <input type="checkbox"/> emphysema <input type="checkbox"/> oxygen use: _____ L / min <input type="checkbox"/> cough <input type="checkbox"/> other _____	<u>Gastrointestinal</u> <input type="checkbox"/> Normal <input type="checkbox"/> stomach ulcer <input type="checkbox"/> change in bowel <input type="checkbox"/> liver problems / <input type="checkbox"/> jaundice <input type="checkbox"/> other _____	<u>Hematologic/Lymphatic</u> <input type="checkbox"/> Normal <input type="checkbox"/> anemia <input type="checkbox"/> bleeding problems <input type="checkbox"/> cancer / <input type="checkbox"/> enlarged lymph nodes <input type="checkbox"/> other _____	<u>Eye/Ear/Nose/Throat</u> <input type="checkbox"/> Normal <input type="checkbox"/> glaucoma <input type="checkbox"/> hearing aid <input type="checkbox"/> plastic surgery _____ <input type="checkbox"/> cataracts / <input type="checkbox"/> other _____
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<u>Psychiatric</u> <input type="checkbox"/> Normal <input type="checkbox"/> depression / <input type="checkbox"/> anxiety <input type="checkbox"/> dementia <input type="checkbox"/> other _____	<u>Endocrine</u> <input type="checkbox"/> Normal <input type="checkbox"/> diabetes / <input type="checkbox"/> thyroid <input type="checkbox"/> oral steroid use <input type="checkbox"/> other _____	<u>Infections</u> <input type="checkbox"/> Normal <input type="checkbox"/> hepatitis (circle): A or B or C <input type="checkbox"/> HIV / AIDS / TB <input type="checkbox"/> cold sores / other _____	<u>Genitourinary</u> <input type="checkbox"/> Normal <input type="checkbox"/> dialysis <input type="checkbox"/> kidney problems <input type="checkbox"/> other _____
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<u>Allergic/Immunologic</u> <input type="checkbox"/> Normal <input type="checkbox"/> lupus <input type="checkbox"/> organ transplantation <input type="checkbox"/> cancer chemotherapy <input type="checkbox"/> other _____	<u>Constitutional</u> <input type="checkbox"/> Normal * <input type="checkbox"/> Current Weight _____ <input type="checkbox"/> fever <input type="checkbox"/> chills <input type="checkbox"/> weight loss	<input type="checkbox"/> *Does your dentist ask you to take antibiotics before dental work? Y / N <input type="checkbox"/> *Are you currently pregnant, planning to become pregnant, or nursing? Y / N <input type="checkbox"/> *Are you allergic to latex or rubber? Y / N <input type="checkbox"/> *Have you ever had radiation or UV treatments? Y / N <input type="checkbox"/> *Previous anesthesia complications? Y / N
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ALL Past 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 / anesthetic allergies and describe reactions (rash, shock, etc.)** (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)?: _____

Roomed by: _____ Dr. Michael Huether's Signature _____ Date _____