MICHAEL J. HUETHER, M.D., P.C./ARIZONA SKIN CANCER SURGERY CENTER, P.C.
MEDICAL HISTORY AND INTAKE FORM

Patient Name: _____ DOB_____/_____/_____ Today's Date: _____

PLEASE MARK THE MEDICAL CONDITIONS THAT YOU CURRENTLY HAVE / HAD IN THE PAST

PAST MEDICAL HISTORY:		**PAST SURGERIES:**	
☐ None	☐ Hearing Loss	☐ None	☐ Kidney Biopsy
☐ Anxiety	☐ HIV/AIDS	☐ Abdominal Surgery	☐ Rectum Surgery
☐ Arthritis	☐ High Cholesterol	☐ Bilateral Knee Replacement **YEAR: _____**	☐ Lumpectomy of Breast R/L
☐ Asthma	☐ **Hyper**thyroidism	☐ Breast Biopsy R/L	☐ Heart Valve Replacement
☐ Atrial Fibrillation	☐ **Hypo**thyroidism	☐ Biopsy of Prostate	☐ Ovary Surgery
☐ Benign Prostatic Hyperplasia	☐ Liver Disease	☐ Heart: Bypass Surgery	☐ Pancreas Surgery
☐ Stroke	☐ Leukemia	☐ Kidney Transplant	☐ Kidney Stone Extraction
☐ COPD	☐ Lymphoma	☐ Excision of Basal Cell Carcinoma	☐ Portosystemic Shunt
☐ Coronary Arteriosclerosis	☐ Tumor of Lung	☐ Excision of Melanoma	☐ Prosthetic Arthroplasty of Bilateral Hips
☐ Depression	☐ Tumor of Breast	☐ Excision of Squamous Cell Carcinoma	☐ Spleen Surgery
☐ Diabetes	☐ Tumor of Colon	☐ Colostomy	☐ Surgical biopsy of Skin
☐ COVID-19	☐ Tumor of Prostate	☐ Tubal Ligation	☐ Kidney Surgery
☐ High Blood Pressure	☐ Radiation Treatment	☐ Appendectomy	☐ Testicle Surgery
☐ End Stage Renal Disease	☐ Bone Marrow Transplant	☐ Breast: Mastectomy B/R/L	☐ Replacement of Hip Joint L/R **YEAR**: _____
☐ Epilepsy	☐ Other	☐ Gall Bladder Surgery	☐ Replacement of Knee Joint L/R **YEAR**: _____
☐ Esophageal Reflux	☐	☐ Colon Surgery	☐ Heart Transplant
☐	☐	☐ Liver Excision	☐ Liver Transplant
☐	☐	☐ Angioplasty	☐ Other
☐	☐	☐ Heart Valve Surgery	☐
☐	☐	☐ Bladder Surgery	☐
☐	☐	☐ Prostate Surgery	☐
☐	☐	☐ Hysterectomy	☐
SKIN DISEASE HISTORY:			
☐ None	☐ Dysplastic Nevus	☐ Psoriasis	**Do you tan in a tanning salon?** ☐ Yes ☐ No
☐ Acne	☐ Eczema	☐ Squamous Cell Carcinoma	**Do you have a family history of skin cancer?** ☐ Yes ☐ No
☐ AK (Precancers)	☐ Asthma	☐ Sunburn of Second Degree	***What type***? _____
☐ Dry Skin	☐ Hay Fever	☐ Other	
☐ Basal Cell Skin Cancer	☐ Melanoma	**Do you wear sunscreen?** ☐ Yes ☐ No	***Which relative***? _____
☐ Poison Ivy	☐ Itchy Scalp	**SPF?**	*Other pertinent family history (only first-degree relatives)*

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ALLERGIES:
Please enter all allergies and **reactions** *or* attach a list *or* circle (**None**):
_____
_____
_____

PLEASE MARK ALL THAT APPLY

SOCIAL HISTORY			
☐ Former Smoker ☐ Never Smoker ☐ Current Smoker	**Alcohol Use Frequency:** ☐ None ☐ Less Than 1 Per Day ☐ 1-2 Per Day ☐ 3 or More Per Day	☐ Drive in Daytime ☐ Drive at Night ☐ Occupation: _____ _____ _____ ☐ **Do you feel safe at home?** ☐Yes ☐No	**Caffeine Usage Frequency**: ☐ several times a day ☐ once a day ☐ few times a week ☐ few times a month ☐ never ☐ other
Exercise Frequency: ☐ several times a day ☐ once a day ☐ few times a week ☐ few times a month ☐ never ☐ other			

REVIEW OF SYSTEMS		**ALERTS**	
☐ None	☐ Sore Throat	☐ Allergy to Adhesive	☐ MRSA
☐ Problems With Healing	☐ Blurry Vision	☐ Allergy to Local Anesthetic	☐ Defibrillator or Pacemaker
☐ High Blood Pressure	☐ Abdominal Pain	☐ Allergy to Latex	☐ Oxygen Use (#Liters/Demand or Continuous) _____
☐ Irregular Heartbeat	☐ Bloody Stool	☐ Artificial Heart Valve	☐ COVID 19 – Traveled Last 14 Days Out of State/Country
☐ Anxiety	☐ Bloody Urine	☐ Artificial Joints Within Past 2 Years	☐ COVID 19 – Exposed to Someone Positive
☐ Rash	☐ Joint Aches	☐ Premedication Prior to Procedures	☐ COVID 19 – Currently Have Symptoms
☐ Hay Fever	☐ Muscle Weakness	☐ Blood Thinners	☐ COVID 19 >=100.4 Degrees (F)
☐ Chest Pain	☐ Headaches	☐ Problems with Bleeding	☐ Allergy to Topical Antibiotic Ointments
☐ Fever or Chills	☐ Seizures	☐ Problems with Scarring (Hypertrophic or Keloid)	☐ Rapid Heartbeat With Epinephrine
☐ Night Sweats	☐ Cough/ Wheezing/ Shortness of Breath	☐ Immunosuppression Transplant/Chemotherapy Medication?	☐ Pregnancy or Planning
☐ Unintentional Weight Loss	☐ Depression	☐ HIV	☐
☐ Thyroid Problems	☐	☐ Hepatitis B or C	☐

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Have you had the pneumonia vaccine? ☐ Yes ☐ No

Do you get the flu vaccine? ☐ Yes ☐ No

Name of Medication	Dosage	How often

Patient or Responsible Party Signature: _____ Date: _____

Reviewed Signature: _____ Date: _____

Reviewed Signature: _____ Date: _____

Reviewed Signature: _____ Date: _____