OKLAHOMA CANCER SPECIALISTS AND RESEARCH INSTITUTE

SKIN CANCER CENTER
800 W. Boise Cir., Ste 400 | Broken Arrow, OK 74012
918.307.0215

PATIENT HISTORY

PLEASE PRINT CLEARLY

Date _____

Name _____ Check One: ☐ Female ☐ Male Age _____

Date of Birth (MONTH/DAY/YEAR) _____ Are you: ☐ Single ☐ Married ☐ Widowed

Were you referred by a physician? ☐ No ☐ Yes

Name of referring physician _____

Please state nature, location and duration of skin problem _____

_____

Previous treatments? _____

Pharmacy: _____ Address: _____ Phone: _____

PERSONAL MEDICAL/SURGICAL HISTORY

Past Medical History (please check all that apply)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Bone Marrow Transplantation
- ☐ 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
- ☐ None

Other: _____

_____

_____

Past Surgical History (please check all that apply)

- ☐ Appendix Removed
- ☐ Bladder Removed
- ☐ Mastectomy (Right, Left, Bilateral)
- ☐ Lumpectomy (Right, Left, Bilateral)
- ☐ Breast Biopsy (Right, Left, Bilateral)
- ☐ Breast Reduction
- ☐ Breast Implants
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Colon: Colostomy
- ☐ Gallbladder Removed
- ☐ Coronary Artery Bypass
- ☐ PTCA
- ☐ Mechanical Valve Replacement
- ☐ Biological Valve Replacement
- ☐ Heart Transplant
- ☐ Joint Replacement, Knee (Right, Left, Bilateral)
- ☐ Joint Replacement, Hip (Right, Left, Bilateral)
- ☐ Joint Replacement within last 2 years
- ☐ Kidney Biopsy
- ☐ Kidney Removed (Right, Left)
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Liver Shunt
- ☐ Liver Transplant
- ☐ Liver Removed
- ☐ Ovaries Removed: Endometriosis
- ☐ Ovaries Removed: Cyst
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas Removed
- ☐ Prostate Removed: Prostate Cancer
- ☐ Prostate Biopsy
- ☐ TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin Biopsy
- ☐ Basal Cell Carcinoma Surgery
- ☐ Squamous Cell Carcinoma Surgery
- ☐ Melanoma Surgery
- ☐ Spleen Removed
- ☐ Testicles Removed (Right, Left, Bilateral)
- ☐ Hysterectomy: Fibroids
- ☐ Hysterectomy: Uterine Cancer
- ☐ Hysterectomy: Cervical Cancer
- ☐ None

Other: _____

_____

Skin Disease History (please check all that apply)

- ☐ 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
- ☐ None

Other: _____

_____

Do you wear sunscreen? ☐ No ☐ Yes If yes, what SPF? _____

Do you tan in a tanning salon? ☐ No ☐ Yes Do you have a family history of Melanoma? ☐ No ☐ Yes

If yes, which relative(s)? _____

MEDICATIONS

List present medications and dosage (including non-prescription and birth control pills):

1. _____ 6. _____

2. _____ 7. _____

3. _____ 8. _____

4. _____ 9. _____

5. _____ 10. _____

ALLERGIES

Are you allergic to any medications? ☐ No ☐ Yes (if yes, specify below)

MEDICATION REACTION

1. _____

2. _____

3. _____

4. _____

SOCIAL HISTORY

(please check all that apply)

- ☐ Currently smokes — daily
- ☐ Currently smokes — not daily
- ☐ Former smoker
- ☐ Never smoked
- ☐ Drug use
- ☐ None of the above

Occupation: _____

Other: _____

REVIEW OF SYSTEMS

(please check all that apply)

- ☐ Unintentional weight loss
- ☐ Headaches
- ☐ Persistent cough
- ☐ Artificial heart valve
- ☐ CPAP
- ☐ History of fever blisters
- ☐ Atypical mole(s)
- ☐ CABG
- ☐ Bleeding problems
- ☐ Wound healing problems
- ☐ Scarring problems
- ☐ Rash
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Yeast infections with antibiotics
- ☐ Stomach upset with antibiotics
- ☐ Abdominal pain
- ☐ Depression
- ☐ Anxiety
- ☐ Bloody stools
- ☐ Bloody urine
- ☐ Blurry vision
- ☐ Fever or chills
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Neck stiffness
- ☐ Night sweats
- ☐ Sore throat
- ☐ Thyroid problems
- ☐ History of melanoma
- ☐ Transplant recipient
- ☐ Immunosuppression
- ☐ Antibiotic before surgery
- ☐ Dialysis
- ☐ Implanted defibrillator
- ☐ Pacemaker
- ☐ Recent chest pain
- ☐ Oxygen use daily
- ☐ Blood thinners
- ☐ Pregnant (or planning pregnancy)
- ☐ Seizures
- ☐ Latex Allergy
- ☐ Local Anesthetic Allergy

Reviewed _____

Revised