Central Carolina Dermatology
Patient Information

NAME:______________________________ AGE:_____ SEX:______ DATE:___________

Personal History of Skin Cancer: Basal Cell Carcinoma______Squamous Cell Carcinoma_________
Melanoma_____Other(specify)_______________________________
Family History of Skin Cancer?______________________________Type?__________________________
Personal History of Other Cancers:____

1. Please check if you have ever had or have any of these diagnoses/problems

	YES	NO		YES	NO
Artifical heart valve			Lung Disease		
Heart Disease			Asthma/Emphysema		
Heart Murmur			Artificial Joint		
Pacemaker/Defibrillator			Pregnant/Breastfeeding		
Blood Clot/Pulmonary Embolism			Seizures/Epilepsy		
Deep Vein Thrombosis			Memory Problems/Dementia		
High Blood Pressure			Stroke		
Hepatitis B			Thyroid Disease		
Hepatitis C			Lupus		
HIV			Rheumatoid Arthritis		
Kidney Disease			Crohn's Disease		
Keloid (Thick) Scarring			Ulcerative Colitis		
Liver Disease			Blood Transfusion		
Tobacco Use-Now			Alcohol Use-Now		
Tobacco Use-Past			Alcohol Use-Past		

2. Check any blood thinning medications you are currently taking:
(Aspirin_____Coumadin______Lovenox______Plavix______)
3. Please list all major operations/surgeries you have had with an approximate date:____________________
____
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4. Please list all medications you are currently taking, including over the counter medications:

___________________ ___________________ ___________________
___________________ ___________________ ___________________
___________________ ___________________ ___________________
___________________ ___________________ ___________________

5. Please list all allergies to medications/herbs, including Latex:

___________________ ___________________ ___________________
___________________ ___________________ ___________________

6. Are there other health issues we should be aware of?____
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Review Date	Initials