HILTON HEAD DERMATOLOGY & SKIN CANCER CENTER, P.A.

Certified, American Board of Dermatology Certified, American Board of Mohs Micrographic Surgery and Cutaneous Oncology

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Cosmetic Laser Surgery
Diseases of the Skin, Hair, & Nails
Dermatologic Reconstructive Surgery
Mohs Micrographic Skin Cancer Surgery

MEDICAL HISTORY

Patient: _____ **Age** _____ **Sex** _____ **Weight** _____ **Date:** _____

Are you allergic to any medications? ☐ Yes ☐ No If **yes**, list: _____
Do you have an Advance Directive? ☐ Yes ☐ No If **yes**, please provide a copy _____

*List all medications you are currently taking. Please also advise us of any illicit drugs you have used.
1. _____ 2. _____
3. _____ 4. _____

	PERSONAL		FAMILY	
	Yes	No	Yes	No
Asthma	☐	☐	☐	☐
Blood Pressure	☐	☐	☐	☐
*Cancer-not skin	☐	☐	☐	☐
*Diabetes	☐	☐	☐	☐
*Glaucoma	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐
Heart Murmur	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐
*HIV (AIDS)	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐
*Melanoma	☐	☐	☐	☐
Phlebitis	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Thyroid	☐	☐	☐	☐

REVIEW OF SYSTEMS		
Any problems with….	**Yes**	**No**
Antibiotics	☐	☐
Blood transfusion	☐	☐
Bleeding excessively	☐	☐
Contact allergy to creams	☐	☐
Defibrillator	☐	☐
General health	☐	☐
Heart/Chest Pain	☐	☐
Healing	☐	☐
Immune system	☐	☐
Need to be pre-medicated	☐	☐
Prosthetic implants	☐	☐
Pacemaker	☐	☐
Thick scars	☐	☐

COSMETIC		
Any interest in….	**Yes**	**No**
Botox	☐	☐
Collagen/Restylane	☐	☐
Freshening Peels	☐	☐
Facials	☐	☐
IPL Photofacial	☐	☐
Laser Rejuvenation	☐	☐
Laser Vein Treatment	☐	☐
Laser Resurfacing	☐	☐
Laser Hair Removal	☐	☐
Microdermabrasion	☐	☐
Skin Tightening	☐	☐
Skin Care Products	☐	☐
Tattoo Removal	☐	☐

Are you pregnant, planning a pregnancy or breast-feeding? ☐ Yes ☐No
Do you smoke? ☐ Yes ☐ No If Yes, _____ packs per day
Do you have artificial joint(s)? ☐ Yes ☐ No
Do you have an artificial heart valve? ☐ Yes ☐No
Do you drink alcohol? ☐ Yes ☐No If Yes, _____ drinks per day
Have you ever had dental anesthesia (Novocaine)? ☐ Yes ☐No Any bad reaction? ☐Yes ☐No

***Skin History*:**

Have you ever had skin cancer? ☐ Yes ☐ No If Yes, list: _____
Are there any untreated skin cancers? ☐ Yes ☐ No If Yes, list: _____
Has anyone in your family had skin cancer? ☐ Yes ☐ No If Yes, list: _____
Do you have a history of any skin diseases? ☐ Yes ☐ No If Yes, list: _____
Is there a family history of skin disease? ☐ Yes ☐ No If Yes, list: _____
When you are exposed to sun, do you: ☐ Tan Only ☐ Tan and burn ☐ Burn

***Please answer the following*:**

Have you ever had a pneumococcal vaccine ☐ Yes ☐ No
*List any other disease or condition we should know about: _____
*List any transplants you have had: _____
What is your occupation? _____
How did you hear about us? _____
What pharmacy do you use? _____
Internist or family physician: _____
Name Street City Zip code