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

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

A. Thomas Bundy, MD, FAAD, FACMS
Emily K. Murphy, FNP-C
Meghan M. Campbell, MS, PA-C
Becca Dugal, DNP, FNP-C

ACMS American College of Mohs Surgery

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

MEDICAL HISTORY

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

Allergies to any medications, dental anesthesia, epinephrine? ☐ 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. _____

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

REVIEW OF SYSTEMS		
Any problems with….	**Yes**	**No**
Anemia	☐	☐
Fever, Diarrhea, Dysuria	☐	☐
Fatigue, Malaise	☐	☐
Visual, Hearing Difficulty	☐	☐
Bleed a lot, + Lymph nodes	☐	☐
Chest pain, Cough	☐	☐
Heart: Abnormal Rhythm	☐	☐
Pacemaker, Defibrillator	☐	☐
Joint Pain/Swelling	☐	☐
Artificial Joint / Heart valve	☐	☐
Poor wound healing, Thick Scars	☐	☐
Seizure, Stroke, Dizziness	☐	☐
Depression, Mood Swings	☐	☐
Need pre-medicated, Implants	☐	☐

COSMETIC INTEREST		
Any interest in….	**Yes**	**No**
Botox	☐	☐
Fillers	☐	☐
Freshening Peels	☐	☐
Facials	☐	☐
IPL Photo facial	☐	☐
Laser Rejuvenation	☐	☐
Laser Vein Treatment	☐	☐
Laser Resurfacing	☐	☐
Laser Hair Removal	☐	☐
Microdermabrasion	☐	☐
Microneedling	☐	☐
Skin Care Products	☐	☐
Tattoo Removal	☐	☐
Waxing	☐	☐

Social and MIPS History:

Are you pregnant, planning a pregnancy or breast-feeding? ☐ Yes ☐No
Do you smoke? ☐ Yes ☐ No If Yes, _____ packs per day
Do you drink alcohol? ☐ Yes ☐No If Yes, _____ drinks per day
Have you ever had the flu vaccine Jan-March ☐ Yes ☐ No October-December ☐ Yes ☐ No
Have you ever had a pneumococcal vaccine ☐ 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*:**

*List any other disease or condition we should know about: _____
*List any transplants you have had: _____
What is your occupation? _____
List any allergen or toxin exposure: _____
How did you hear about us? _____
What pharmacy do you use? _____
Internist or family physician: _____
Name Street City Zip code