WACCAMAW DERMATOLOGY
Skin Cancer Institute

Phone: (843) 449-0453 Fax: (843) 449-9531
www.waccamawdermatology.com

Medical History Form

Last Name: _____ First Name: _____ DOB:_____

Past Medical History (please circle any that apply and use the lines below for anything else)
Anxiety Arthritis Asthma Atrial Fibrillation Stroke COPD Depression Diabetes Hypertension Kidney Disease Seizures GERD Glaucoma Heart Disease Hepatitis HIV Hypercholesterolemia Leukemia Stomach Ulcer Thyroid Disease Previous Radiation Cancer (type): _____

_____

_____

Previous Surgeries:

_____

_____

History of skin cancer (please circle any that apply):

Basal Cell Squamous Cell Melanoma Other: _____

Other Skin conditions: _____

Family History of Melanoma? Yes/No If so, who? _____

Please list any medications (including blood thinners), supplements (including fish oil), infusions, etc you are currently taking:

_____

_____

_____

_____

Please list any drug allergies & your reaction:

_____

Social History (please circle any that apply):

Smoking History: Never Smoked Former Smoker Current Smoker Packs per day:_____

Do you drink alcohol: Yes No How many drinks per day: _____

What is your place of residence? _____ Do you feel safe at home?_____

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Patient Name: _____

Vaccinations

Have you gotten a flu vaccine this year? Yes / No

Have you received the pneumonia vaccine (65+)? Yes / No

Advanced Care Planning

Do you have a healthcare proxy? Yes / No If yes, who? _____

Do you have a living will? Yes / No

Family History (please list chronic or severe diseases as appropriate):

Mother: _____ Father: _____

Maternal Grandmother: _____ Maternal Grandfather: _____

Paternal Grandmother: _____ Paternal Grandfather: _____

Siblings: _____

Review of Systems (please circle any that apply):

Weight change Vision Skin Rash Breathing Difficulty Cough Chest Pain Diarrhea Dizziness

Easy Bleeding Swollen Ankles Tremor/Seizures Muscle Weakness Nausea Vomiting Constipation

Tiredness Fever Confusion Insomnia Skin Lesions Difficulty Urinating Loss of Taste Numbness

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I ALSO CERTIFY THAT I WILL REPORT CHANGES IN MY HEALTH HISTORY TO MY HEALTH CARE PROVIDER.

Signature: _____ Date: _____

FOR REPEAT VISITS, IF THERE ARE NO CHANGES TO YOUR HEALTH HISTORY SINCE YOU LAST COMPLETED THIS FORM, PLEASE SIGN AND DATE BELOW:

Signature: _____ Date: _____