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PLEASE COMPLETE THE FOLLOWING MOHS MEDICAL HISTORY FORM

Name: ______________________________ Date of Birth: __________ Referred by: ____________________

History of today's problem
Skin area involved: ________________________________ How long has problem been present __________
Was there any previous treatment? ☐Yes ☐ No ☐ When? __________
Type of Treatment: ☐ burning ☐ radiation ☐excision ☐ liquid nitrogen ☐other____________________
Was a biopsy done? ☐Yes ☐No ☐biopsy done by referring doctor
Please mark none; if no specialist: Internist: ______________________________ **Cardiologist:** ____________________
Ophthalmologist: ____________________ **Radiologist/Oncologist:** ____________________________

CHECK ALL THAT APPLY TO TODAY'S PROBLEM
Quality - A change of: ☐ size ☐color ☐ elevation ☐ hardness ☐none ☐ other ____________________
Modifying Factors - a history of: ☐none ☐UV light treatments ☐arsenic exp/treatments ☐chronic scar ☐x-ray treatments (not routine dental or chest x-rays) ☐immunosuppression
Associated Symptoms: ☐ bleeding ☐ pain ☐ tingling ☐ ulceration ☐ infection ☐ itching ☐ other ________
Severity: ☐ no symptoms ☐occasional symptoms ☐constant symptoms

SYSTEMS REVIEW - CHECK ALL THAT APPLY REGARDING YOUR HEALTH AND ADD OTHER IMPORTANT PROBLEMS
Medications: Allergic to any medications? ☐none ☐yes list them: ________________________________
On any medication now? ☐none ☐yes list them: ____
On any blood thinners? ☐none ☐yes last taken: ____
Are you taking any Aspirin or Aspirin-like products (e.g. Aleve, Bufferin, and Motrin) ☐no ☐yes last taken: ______

Infections	**Hematologic/lymphatic**	**Constitutional Symptom**	**Eyes/Ears/Nose/Throat**
☐none	☐normal	☐none	☐normal
☐HIV/AIDS	☐anemia	☐weight loss/weight gain	☐glaucoma
☐hepatitis	☐bleeding problems	☐fever	☐hearing aid
☐tuberculosis (T.B.)	☐enlarged lymph nodes	☐other: ____________	☐plastic surgery: ____________
☐other: ____________			
Cardiovascular	**Respiratory**	**Gastrointestinal**	**Musculoskeletal**
☐normal	☐normal	☐normal	☐normal
☐angina	☐asthma	☐stomach ulcer	☐arthritis
☐artificial limb	☐emphysema	☐colitis	☐artificial joint
☐pacemaker	☐COPD	☐other GI problems:	☐other:
☐hypertension	☐other lung problems:	____________________	____________________
☐mitral valve prolapse	____________________		
Neurological	**Psychiatric**	**Endocrine**	**Skin**
☐normal	☐normal	☐normal	☐abnormal scarring
☐stroke	☐depression	☐diabetes	☐poor healing
☐seizures	☐anxiety attacks	☐thyroid	☐other skin disorders
☐other: _________	☐other: ____________	☐other: ____________	☐other _________

HISTORY:
Previous skin cancer - ☐none ☐see chart List: location/date ______________________________
Major illness or hospitalizations: ☐ none List: ____
____
Do you take antibiotics prior to dental or other procedures? ☐Yes ☐ no if yes, what? ____________________
Family History: skin cancer ☐none ☐melanoma ☐basal cell ☐squamous cell list: ____________________
____
Do you - Wear: ☐ dentures ☐glasses ☐ contact lenses **Smoke:** ☐yes packs per day ____ ☐no ☐former smoker
Drink alcohol: ☐no ☐social/occasional drinking only ☐ other ______________________________
Alcohol or drug problems/addictions: ☐none ☐yes, describe ________________________________