Please complete and bring with you the day of your consultation.

Name_____Date of Birth_____ Age_____

Physician requesting consultation_____
Primary Care Physician_____
Name and address

Why are you coming to see us today?_____
What symptoms do you have? (circle) itching / bleeding / rapid growth / painful / other_____
How long has it been there?_____ Was area biopsied?_____
Was area treated in the past? Yes / No circle: frozen / creams / radiation / surgery
Family History of Skin Cancer: _____
History of radiation to the area? _____ History of Arsenic Exposure: _____

Medications:

Please list **ALL medications** that you take, including over the counter medicines and herbs.

_____ _____ _____
_____ _____ _____
_____ _____ _____

Do you take (circle): Aspirin / Coumadin / Plavix / Pradaxa / Ticlid / Vit E / Fish Oil
Prednisone / Advil / Ibuprofen / Motrin / Naproxen

List **Medication Allergies** (including creams and ointments):

_____ _____ _____
_____ _____ _____

Are you allergic to **Latex?** Yes / No

General Health: (circle all that apply)

Overall, how do you feel?
Excellent / Good / Fair / Sick

Do you experience:
Frequent fevers / excessive fatigue / weight loss

Heart Disease: (circle all that apply)

Angina	Heart attack	Irregular heart beats
Angioplasty	Heart failure	Pacemaker
Atrial fibrillation	Heart murmur	Stents
Bypass surgery	Heart valve disease	Other
Defibrillator	High blood pressure	

Hematological: (circle all that apply)

Anemia Bleeding problems Easily bruise Low platelets Transfusions
Do you see a hematologist? Yes / No
What do you see the hematologist for?_____
Name and address of hematologist_____
_____

Neurological: (circle all that apply)
Cerebral shunt Frequent headaches Seizures Stroke TIA
Other_____

Infectious Disease: (circle all that apply)
Hepatitis HIV Tuberculosis Other_____

Wound Infections: (circle all that apply)
Tendency to infections Staph MRSA Exposure to MRSA Explain_____

Psychiatric: (circle all that apply)
Anxiety Fainting spells Depression Other_____

Skeletal/Muscular: (circle all that apply)
Arthritis Knee replacement Hip replacement Other_____

Pulmonary: (circle all that apply)
Asthma Cough Emphysema Shortness of breathe Other_____

Cancers: (circle all that apply)
Breast Colon Leukemia Lung Lymphoma Prostate Other_____

Liver Disease: (circle all that apply)
Cancer Cirrhosis Hepatitis B Hepatitis C Other_____

Genitourinary: (circle all that apply)
Kidney disease Transplant Benign Prostatic Hypertrophy Other_____
Dialysis -- Days of the week you go to dialysis_____

Gastrointestinal: (circle all that apply)
Frequent GI upsets Irritable Bowel Reflux Ulcers Other_____

Endocrine: (circle all that apply)
Diabetes Hyperthroid Hypothyroid Other_____

Eyes: (circle all that apply)
Cataracts Eye pain Glaucoma Loss of vision Tearing Other_____

Ear /Nose/ Throat: (circle all that apply)
Decreased hearing Hearing aides Draining allergies Restricted nasal breathing
Surgery Other_____

Other Surgeries:Explain_____
Do you require Antibiotics prior to dental work or surgery? Yes / No

Social History: (circle all that apply)
Alcohol: daily weekends social rarely never
Smoking: Yes / No _____packs a day
Marital status: Single Married Divorced Widowed
Occupation_____

_____ _____ _____
physician signature nurse signature date