ARIZONA MOHS SURGERY
ANIR DHIR MD, FACMS

ARIZONA MOHS SURGERY, P.L.L.C.
MEDICAL HISTORY FORM

Today's Date:	Primary Care Doctor:

PATIENT INFORMATION

Last Name:	First:	Middle:	Birth Date: / /

Pharmacy:	**Address:**

Referring Physician:

Other Specialists:

Do you have issues with: (Please circle all that apply) **Poor Healing** **Bleeding** **Scarring** **Immunosuppression** **Fainting**

SKIN CANCER & DERMATOLOGIC HISTORY

Melanoma? Yes No Locations and dates:

BRAF Inhibitors (e.g. Yervoy) ? Yes No

Basal Cell Skin Cancer? Yes No Locations and dates:

Squamous Cell Skin Cancer? Yes No Locations and dates:

Other Skin Cancer? Yes No Type? Location / Year:

Actinic Keratoses (Pre Cancers)	Yes	No	Blistering Sunburns	Yes	No
Precancerous / Atypical Moles	Yes	No	Psoriasis (PUVA, Cyclosporine)	Yes	No

YOUR PERSONAL MEDICAL HISTORY

Anticoagulant Therapy	Yes	No	GERD	Yes	No
Anxiety	Yes	No	Hearing Loss	Yes	No
Arthritis	Yes	No	Heart Attack (MI)	Yes	No
Asthma	Yes	No	Hepatitis B or C	Yes	No
Atrial Fibrillation	Yes	No	Herpes / HSV / Cold Sores	Yes	No
Blood Clots	Yes	No	HIV / AIDS	Yes	No
Bone Marrow Transplant	Yes	No	High Cholesterol	Yes	No
BPH (Enlarged Prostate)	Yes	No	Hypertension (Blood Pressure)	Yes	No
Breast Cancer	Yes	No	Hyperthyroidism	Yes	No
CLL / Chronic Leukemia	Yes	No	Hypothyroidism	Yes	No
Colon Cancer	Yes	No	Lung Cancer	Yes	No
COPD / Emphysema	Yes	No	Lupus	Yes	No
Coronary Artery Disease	Yes	No	Lymphoma	Yes	No
Dementia / Alzheimer's	Yes	No	Multiple Sclerosis	Yes	No
Depression	Yes	No	Prostate / Ovarian Cancer	Yes	No

Diabetes	Yes	No	Radiation Treatment	Yes	No
Dialysis / Kidney Disease	Yes	No	Rheumatoid Arthritis	Yes	No
Epilepsy (Seizures)	Yes	No	Seasonal Allergies	Yes	No
Facial Trauma	Yes	No	Stroke	Yes	No
Fainting / Syncope	Yes	No	Throat / Mouth Cancer	Yes	No

Other?

SURGICAL HISTORY

Solid Organ Transplantation? Kidney Liver Heart Lung Year:_____ History of rejection? Y N

Joint Replacement? Knee Hip Shoulder Other: _____ Month / Year:

Defibrillator	Yes	No	Hysterectomy	Yes	No
Pacemaker	Yes	No	Ovaries (Tubal Ligation)	Yes	No
Heart Valve Replacement	Yes	No	Colon (Colectomy / Colostomy)	Yes	No
Coronary Artery Bypass or Stents	Yes	No	Prostatectomy	Yes	No
Breast Lumpectomy / Mastectomy	Yes	No	Implanted Nerve Stimulator	Yes	No

Cosmetic / Plastic Surgeries (type and year):

Other Surgeries?

FAMILY HISTORY

Melanoma and/or Atypical Moles (e.g. FAMMM)	Yes	No	Family member:
Basal Cell Carcinoma?	Yes	No	Family member:
Squamous Cell Carcinoma?	Yes	No	Family member:
Other Skin Cancer? Type?	Yes	No	Family member:
Breast / Colon Cancer?	Yes	No	Family member:
Pancreatic Cancer?	Yes	No	Family member:
Ovarian / Uterine / Bladder Cancer?	Yes	No	Family member:

SOCIAL HISTORY

Occupation:	Hobbies:

How often do you exercise?

Smoking Status	Never Quit Less than Daily Daily ____ # packs per day ____ # years
Caffeine Intake	None < 1 cup per day 1-2 cups per day 3 or more cups per day
Alcohol Consumption	None < 1 Drink per day 1-2 drinks per day 3 or more drinks per day
Do you use sunscreen?	None Daily Occasionally What SPF?
Tanning bed use?	Never Previous Current Total # Visits _____
Illicit Substance Use?	Never Cocaine Heroin Methamphetamines Other:

FOR WOMEN ONLY

Are you pregnant?	Yes	No	Are you breastfeeding?	Yes	No

Are you taking oral contraceptives? Yes No

CURRENT MEDICATIONS (PLEASE INCLUDE HERBAL SUPPLEMENTS)

May we electronically verify your medication history? ☐ Yes ☐ No

Medication:	Dose:	Medication:	Dose:
Medication:	Dose:	Medication:	Dose:
Medication:	Dose:	Medication:	Dose:
Medication:	Dose:	Medication:	Dose:
Medication:	Dose:	Medication:	Dose:
Medication:	Dose:	Medication:	Dose:
Medication:	Dose:	Medication:	Dose:

ALLERGIES

Medication Allergies? Yes No Please list medications and type of reaction:

Sensitivities to the following? Adhesives Latex Lidocaine Epinephrine Neosporin Bacitracin Bactroban

CURRENT SYMPTOMS

Fatigue	Yes	No	Healing problems	Yes	No	Rash / itch	Yes	No
Unintended weight loss	Yes	No	High blood pressure	Yes	No	Acute visual changes	Yes	No
Fever	Yes	No	Irregular heart beat	Yes	No	Swollen lymph nodes	Yes	No
Chills	Yes	No	Headache	Yes	No	Joint aches	Yes	No
Blood clots	Yes	No	Seizures	Yes	No	Anxiety	Yes	No
Easy bruising	Yes	No	Nausea / vomiting	Yes	No	Depression	Yes	No
Chronic cough	Yes	No	Abdominal pain	Yes	No	Bloody stool	Yes	No
Shortness of breath	Yes	No	Constipation	Yes	No	Bloody urine	Yes	No
Chest pain	Yes	No	Diarrhea	Yes	No	Muscle weakness	Yes	No

VACCINATIONS

Have you had the pneumonia vaccine?	Yes	No	Have you had the flu vaccine?	Yes	No

ALERTS

Allergy to Local Anesthetic	Yes	No	Allergy to Adhesives	Yes	No
Rapid Heart Rate with Epinephrine	Yes	No	Allergy to Latex	Yes	No
Defibrillator or Pacemaker	Yes	No	Immunosuppression	Yes	No
Artificial Joint within Past 2 Years	Yes	No	HIV	Yes	No
Artificial Heart Valve	Yes	No	Hepatitis B or C	Yes	No
Premedication before Procedures	Yes	No	MRSA	Yes	No
Blood Thinners	Yes	No	Oxygen Use	Yes	No
Problems with Bleeding	Yes	No	Pregnancy or Planning	Yes	No