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 / 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	**Defibrillator**
Bypass surgery	Heart valve disease	**Heart Valve replacement**
Stents	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