WESTLAKE DERMATOLOGY & Cosmetic Surgery

Mohs Medical History Form

The answers to these questions will help us provide better care during your upcoming procedure. Please complete both pages of the Medical History Form.

Name _____ **Date of birth** _____

Dermatologist _____ **Primary Physician** _____

Main reason for today's visit _____

Has this been treated in the past?	☐ No	☐ Yes (how?) _____
Do you require antibiotics before procedures?	☐ No	☐ Yes (why?) _____
Have you ever had an organ transplant?	☐ No	☐ Yes
Do you have a pacemaker or defibrillator?	☐ No	☐ Yes
Do you take blood thinners?	☐ No	☐ Yes _____
Do you have any allergies to medications/latex/adhesive?	☐ No	☐ Yes (list)_____
Do you use tobacco?	☐ No	☐ Yes

Occupation _____

Marital Status: ☐ Single ☐ Partner/Married ☐ Divorced ☐ Widowed

Who lives at home with you? _____

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Patient Name: _____ **DOB:** _____

REVIEW OF SYMPTOMS: ***Please check any current symptoms you have:***

- ☐ Recent fevers/sweats
- ☐ Unexplained weight loss/gain
- ☐ Unexplained fatigue/weakness
- ☐ Change in vision
- ☐ Ears/Nose/Throat/Mouth
- ☐ Difficulty hearing/ringing in ears
- ☐ Hay fever/Allergies/ Congestion
- ☐ Trouble swallowing
- ☐ Chest pains/discomfort
- ☐ Palpitations
- ☐ Cough/wheeze
- ☐ Coughing up blood
- ☐ Heartburn/reflux
- ☐ Blood or change in bowel movement
- ☐ Nausea/vomiting/ diarrhea
- ☐ Pain in abdomen
- ☐ Painful/bloody urination
- ☐ Unusual vaginal bleeding
- ☐ Leaking urine
- ☐ Nighttime urination
- ☐ Discharge: penis or vagina
- ☐ Concern with sexual functions
- ☐ Muscle/joint pain
- ☐ Recent back pain
- ☐ Rash
- ☐ New or change in mole
- ☐ Headaches
- ☐ Memory loss
- ☐ Fainting
- ☐ Anxiety/stress
- ☐ Sleep problem
- ☐ Unexplained lumps
- ☐ Easy bruising/bleeding
- ☐ Cold/heat intolerance
- ☐ Increase thirst/appetite

Patient Signature: _____ **Date:** _____

Please complete this section only if you are <u>new patient</u> to Westlake Dermatology:

Medications (prescription and over the counter): _____

_____

_____

PAST MEDICAL HISTORY: *Please indicate whether you have had any of the following medical problems:*

- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Diabetes
- ☐ Thyroid problem
- ☐ Other: _____
- ☐ Asthma/Lung disease
- ☐ Heart Disease
- ☐ Stroke
- ☐ Easy Bleeding

☐ Skin Cancers (if yes, list locations / date):

_____