Skin Surgery Center of Missouri

Patient Medical History Form

Name: ______________________ Date of Birth: ______________ S.S.# : ________________

Address: ________________________________ City: _______________ Zip: __________

Home Ph: ________________ Alt. Ph: ________________ Email: ______________________

Emergency Contact: ______________________________ Phone #: _____________________

Primary Care Physician: ______________________ Referring Physician: ____________________

Please indicate if you have any of the following:

Past Medical History:	**Yes**	**No**	**Date of most recent /Describe / Comment:**
Bleeding Disorders:	☐	☐	____________
Organ Transplant:	☐	☐	____________
Cancer (Solid Tumors):	☐	☐	____________
Lymphoma/Leukemia:	☐	☐	____________
Heart/Heart Valve Problems:	☐	☐	____________
Joint Replacement:	☐	☐	____________
Diabetes:	☐	☐	____________
Liver Problems:	☐	☐	____________
Pacemaker/Defibrillator:	☐	☐	____________
Immunosuppressants:	☐	☐	____________
Previous Skin Cancer:	☐	☐	____________
High Blood Pressure:	☐	☐	____________
HIV/AIDS:	☐	☐	____________
Hepatitis	☐	☐	____________
Cold Sores/Fever Blisters	☐	☐	____________
Other medical conditions	☐	☐	____________

Any Recent History of:	**Yes**	**No**	**Date of most recent / Describe/ Comment:**
Nausea/Vomiting:	☐	☐	____________
Fevers/Chills:	☐	☐	____________
Shortness of Breath:	☐	☐	____________
Dizziness:	☐	☐	____________
Chest Pain:	☐	☐	____________

Are you allergic or suffer from adverse reactions to any medications? If yes, please list them below:

____

Please list all of your medications and doses: (Continue on back if needed)

____

Do you need to take antibiotics prior to surgery or dental procedures: ☐ No ☐ Yes

Do you smoke cigarettes or chew tobacco? ☐ No ☐Yes Are you allergic to latex? ☐ No ☐Yes

Do you drink alcohol? ☐ No ☐Yes If so, how much per week? ____________________

Signature of person completing this form: ____________________ Date: ________________

Physician's signature: ________________________ Date: ____________________