Dermatology Center of Richmond., Dr. Hayri E. Sangiray

MEDICAL HISTORY FORM

Date: _____

Name _____ Birthdate _____ ☐ M ☐ F

Consult requested by: ☐ Dr. _____ Referred by:☐ Self ☐ Friend _____

Reason for today's visit: _____

Accompanied by: _____ Pharmacy name/address:_____

Past Medical History

☐ High blood pressure
☐ Heart disease
☐ Heart valve dysfunction
☐ Artificial Heart Valve
☐ Pacemaker
☐ Artificial joint
☐ Needs antibiotics prior to dental procedure

Check all that apply and add any other important problems

☐ Diabetes
☐ HIV/AIDS
☐ Hepatitis B
☐ Hepatitis C
☐ Cirrhosis
☐ Organ transplant
☐ Pregnant
☐ Breastfeeding
☐ Stroke
☐ Abnormal scarring/keloids
☐ Renal failure
☐ Myelodysplastic synd.
☐ Implantable neurological device
☐ Depression
☐ Anxiety attacks
☐ Faints easily
☐ Leukemia/lymphoma
☐ Abnormal platelet
☐ Tuberculosis
☐ none

Previous Skin Cancer ☐ none ☐ yes/list: Location/Date/Treatment type_____

Other Major illnesses/cancer, Surgeries ☐ none ☐ yes/list: _____

_____

Family History: Is there a history of skin cancer? ☐ None ☐ basal cell ☐ squamous cell ☐ melanoma

Social History: Do you Smoke? ☐ No ☐ former ☐ yes, packs per day _____
What is your occupation? _____

Is English your main language? ☐ No ☐ Yes Do you have any problems with mobility? ☐ No ☐ Yes
Do you have any beliefs/practices that might affect how we treat you (religious, cultural, spiritual)? ☐ No ☐ Yes

_____

Do you have any problems with your vision or hearing that might affect how we teach you? ☐ No ☐ Yes

_____

Do you use sunscreen(circle one) Yes No If yes what SPF?_____
Have you ever used a tanning bed(circle one) Yes No