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: □ Mohs □ Skin Cancer monitoring □ suspicious lesion □ other _____

Accompanied by: _____ Pharmacy /location: _____/_____

System Review **Allergies to Medications:** *(Complete second page of this form)*

Check all that apply and add any other important problems □ none

□ New or changing mole/lesion □ bleeding problems □easy bruising □enlarged lymph nodes

□ Refer to **History of Todays problem(s)** above.

Past Medical History	**Check all that apply and add any other important problems** □ none		
□ High blood pressure	□ Diabetes	□ Pregnant	□ Depression
□ Heart disease	□ HIV/AIDS	□ Breastfeeding	□ Anxiety attacks
□ Heart valve dysfunction	□ Hepatitis B	□ Stroke	□ Faints easily
□ Artificial Heart Valve	□ Hepatitis C	□ Abnormal scarring/keloids	□ Leukemia/lymphoma
□ Pacemaker	□ Hepatitis/Cirrhosis	□ Renal failure	□ Abnormal platelet
□ Artificial joint	□ Blood Transfusions	□ Organ transplant	□ Myelodysplastic synd.
□ Needs antibiotics prior to dental procedure	□ Implantable neurological device		□ Tuberculosis

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

Other Major illnesses/cancer, Surgeries or Hospitalizations □ none □ yes/list:

Family History: Is there a history of skin cancer? □ None □ basal cell □ squamous cell
□ melanoma (relationship to patient:_____)

Social History: Do you Smoke? □ No □ former □ yes, packs per day _____