JOHN A. ZITELLI, M.D. & DAVID G. BRODLAND, M.D.

Name_____ **DOB** _____ **Age** _____

EMAIL_____ **Home#**_____

Cell_____ **Pharmacy Name & phone:**_____

Emergency: Contact Primary Name/Relation/phone#_____

Secondary Name/Relation/Phone#_____

Can we discuss health information with your emergency contact? [ ] yes [ ] no

Referred by: [ ] Self or [ ] Dr. _____

PCP name/phone#_____

HISTORY OF TODAYS PROBLEM ONLY:

Skin areas involved_____

How long has the problem been present?_____

Was a biopsy done? No [ ] Yes [ ] Was the biopsy done by referring doctor? [ ] No [ ] Yes

Was there any treatment after biopsy? [ ] No [ ] Yes When and what type of treatment?

_____

CHECK ALL THAT APPLY TO TODAY'S PROBLEM

A change in :	A history of :	Associated Symptoms	Severity
[ ] size	[ ] X-ray treatments (for acne)	[ ] bleeding	[ ] no symptoms
[ ] color	[ ] UV light treatments	[ ] tingling	[ ] occasional symptom
[ ] elevation	[ ] tanning bed use	[ ] pain	[ ] constant symptoms
[ ] hardness	[ ] arsenic exposure	[ ] ulceration	
[ ] quality	[ ] chronic scar	[ ] infection	
[ ] none	[ ] immunosuppression	[ ] itching	
	[ ] none	[ ] none	

Check all that apply regarding your health and add any other important problems

HEMATOLOGIC/LYMPHATIC
- **[ ] normal/none**
- [ ] blood transfusions
- [ ] bleeding problems
- [ ] enlarged lymph nodes

SKIN
- **[ ] normal/none**
- [ ] abnormal scarring
- [ ] poor healing
- [ ] other skin disorders

CONSTITUTIONAL SYPTOMS
- **[ ] normal/none**
- [ ] weight loss
- [ ] fever
- [ ] night sweats

EYES/EARS/NOSE/THROAT
- **[ ] normal/none**
- [ ] glaucoma
- [ ] hearing aids
- [ ] plastic surgery

NEUROLOGICAL
- **[ ] normal/none**
- [ ] stroke
- [ ] seizures
- [ ] other disorders

RESPIRATORY
- **[ ] normal/none**
- [ ] asthma
- [ ] emphysema
- [ ] other lung problems _____
- [ ] COPD
- [ ] Are you on oxygen? _____

INTESTINAL/URINARY
- **[ ] normal/none**
- [ ] stomach ulcers/colitis
- [ ] colon/bladder/kidney cancer
- [ ] other GI/GU problems

MUSCULOSKELETAL
- **[ ] normal/none**
- [ ] arthritis
- [ ] artificial joint
- [ ] _____

CARDIOVASCULAR
- **[ ] normal/none**
- [ ] artificial heart valve
- [ ] High blood pressure
- [ ] Pacemaker
- [ ] A- Fib
- [ ] Infectious endocarditis
- [ ] Unrepaired congenital heat valve

PLEASE TURN OVER TO COMPLETE OTHER SIDE OF THIS PAPER

PSYCHIATRIC

[ ] normal/none
[ ] depression
[ ] anxiety
[ ] other psych disorders

ENDOCRINE

[ ] normal/none
[ ] diabetes
[ ] thyroid condition
[ ] other endocrine disorder

INFECTIONS

[ ] normal/none
[ ] hepatitis type_____
[ ] HIV/AIDS
[ ] Tuberculosis (T.B.)
[ ] other contagious disease _____

GENDER IDENTIFICATION [ ] Male [ ] Female [ ] Gender Queer [ ] Female-to-Male Transgender Male
[ ] Male-to-Female Transgender Female [ ] Additional category (please describe) _____

PAST HISTORY **PREVIOUS SKIN CANCER: [ ] None [ ] Yes/list: Type/Site & Date**_____

_____

Major Illnesses or Hospitalizations: [ ] None [ ] Yes/list:_____

Organ Transplant Recipient: [ ] No [ ] Yes/Type:_____

FAMILY HISTORY OF SKIN CANCER **[ ] None [ ] Basal cell [ ] Squamous cell [ ] Melanoma**

Relationship:_____

SOCIAL HISTORY **Occupation:**_____ **Marital status**: [ ] S [ ] M [ ] D [ ] W

Do you wear: [ ] Dentures [ ] Glasses [ ] Contact lenses [ ] Hearing aids

Smoking: [ ] No [ ] Former [ ] Yes/packs per day_____

Alcohol: [ ] No [ ] YES **If yes, how many times in the past year have you had: Men:** ≥5 drinks in a day _____

Women: ≥4 drinks in a day_____ **Alcohol/Drug problems/addictions**: [ ] None [ ] Describe _____

Height (inches): _____ **Weight:** _____

Did someone other than the patient provide the information above? [ ] No [ ] Yes- who and why_____

DO YOU WANT PHOTOS UPLOADED TO YOUR ONLINE PORTAL? [ ] No [ ] YES

MEDICATIONS AND ALLERGIES

Medication/OTC/Supplements	Dosage	Frequency	Route

NO MEDICATIONS [ ] **NO ALLERGIES TO MEDICATIONS [ ]**

Allergies to Medications	Reactions