

# **Knight Dermatology Institute**

The Center for Cosmetic and Laser Skin Surgery

**J. Matthew Knight, M.D.**

## **PATIENT HEALTH HISTORY**

Date \_\_\_\_\_

Name \_\_\_\_\_ SSN \_\_\_\_\_ DOB \_\_\_\_\_  
Title Last First Middle

Birthplace \_\_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Marital Status \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

### **Allergies**

<b>MEDICATION ALLERGIES</b>	<b>OTHER ALLERGIES</b>

\*\*Are you allergic to local anesthetics (lidocaine, novocaine, etc.)? \_\_\_\_\_

### **Current Medications**

Please list **all** medications that you take, *including over-the-counter drugs, vitamins, herbal supplements, diet aids, etc.*  
Attach list if applicable.

- |          |          |           |
|----------|----------|-----------|
| 1. _____ | 5. _____ | 9. _____  |
| 2. _____ | 6. _____ | 10. _____ |
| 3. _____ | 7. _____ | 11. _____ |
| 4. _____ | 8. _____ | 12. _____ |

### **Personal Medical History** (Please list all of your past and current medical problems)

Attach list if applicable.

<b>MEDICAL PROBLEM</b>	<b>YEAR DIAGNOSED</b>	<b>TREATING PHYSICIAN(S)</b>

Have you ever had skin cancer (including melanoma)?

<b>TYPE OF SKIN CANCER</b>	<b>YEAR</b>	<b>SITE ON YOUR BODY</b>	<b>DOCTOR</b>	<b>TREATMENT/OUTCOME</b>

Do you have?

An implanted heart pacemaker/defibrillator? Yes No What type \_\_\_\_\_

Any other implanted medical device (i.e. TENS unit, brain stimulator, pump, etc.)? Yes No What type \_\_\_\_\_

**PLEASE SEE SECOND PAGE FOR MORE HEALTH HISTORY QUESTIONS**

Reviewed by \_\_\_\_\_ Date \_\_\_\_\_

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Have you ever been diagnosed with (check all that apply)

Skin "pre" cancers ("AKs")       Yes       No      Treatments (i.e. liquid nitrogen) \_\_\_\_\_  
Contact Dermatitis               Yes       No      When \_\_\_\_\_ Cause (if known) \_\_\_\_\_  
Asthma                               Yes       No      When \_\_\_\_\_  
Atopic Dermatitis                 Yes       No      When \_\_\_\_\_ Treatment \_\_\_\_\_  
Psoriasis                           Yes       No      When \_\_\_\_\_ Treatment \_\_\_\_\_  
Other skin rash/diagnosis       Yes       No      When \_\_\_\_\_ Name of skin problem(s) \_\_\_\_\_  
Hepatitis C or B                  Yes       No  
HIV/AIDS                          Yes       No

Do you drink alcohol             Yes       No      How often/what type of alcohol \_\_\_\_\_  
Do you smoke tobacco          Yes       No      How often \_\_\_\_\_  
Do you use tanning booths      Yes       No      How often \_\_\_\_\_  
Do you sunbathe                 Yes       No      How often \_\_\_\_\_

Have you ever:

Had cosmetic surgery          Yes       No      What type \_\_\_\_\_  
Been treated with a laser       Yes       No      Reason \_\_\_\_\_  
Had Botox injections           Yes       No      When was the last time \_\_\_\_\_  
Had collagen/filler injections  Yes       No      What type \_\_\_\_\_ Where on your body \_\_\_\_\_

If female:

Are you pregnant                Yes       No      Last menstrual period \_\_\_\_\_  
Are you trying to become pregnant  Yes       No      Type of birth control \_\_\_\_\_

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**Family History** Are you adopted?       Yes       No

Have any of your blood relatives ever had skin cancer?       Yes       No

Have any of your relatives died of skin cancer or a skin related illness?       Yes       No

Do any of your relatives have a skin condition or disease?       Yes       No

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### **Review of Systems**

Have you experienced any of the following in the past three months? If you have seen a doctor for these problems, please list

Weight loss (non-intentional)       Yes       No      \_\_\_\_\_  
A decrease in appetite               Yes       No      \_\_\_\_\_  
Increased tiredness                  Yes       No      \_\_\_\_\_  
Difficulty breathing                  Yes       No      \_\_\_\_\_  
Chest pain                              Yes       No      \_\_\_\_\_

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As skin cancer can develop on any area of the body, it is this practice's policy to routinely examine almost all areas of the skin, including the breasts, during a comprehensive skin examination. We also request that all makeup and nail polish be removed prior to arrival, as both can mask skin cancer. If you do not want a comprehensive skin examination for any reason, please inform your doctor / practitioner immediately.

Patient (or guardian) signature \_\_\_\_\_ Date \_\_\_\_\_

Dr. Knight and his staff thank you for your time.  
We look forward to seeing you soon.

Reviewed by \_\_\_\_\_ Date \_\_\_\_\_