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

MEDICATION ALLERGIES	OTHER ALLERGIES

**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.

MEDICAL PROBLEM	YEAR DIAGNOSED	TREATING PHYSICIAN(S)

Have you ever had skin cancer (including melanoma)?

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

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 _____

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	_____

As skin cancer can develop on <u>any</u> 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 _____