

Michael J. Huether, M.D., P.C.
 Arizona Skin Cancer Surgery Center, P.C.
History and Intake Form

Patient Name _____ **D.O.B** ____/____/____ **Today's Date** _____

Past Medical History: (please mark the medical conditions that you currently have)

<input type="checkbox"/> None	
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Hearing Loss
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Bone Marrow Transplant	<input type="checkbox"/> Hypercholesterolemia
<input type="checkbox"/> BPH	<input type="checkbox"/> Hyperthyroidism
<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Hypothyroidism
<input type="checkbox"/> Colon Cancer	<input type="checkbox"/> Leukemia
<input type="checkbox"/> COPD	<input type="checkbox"/> Lung Cancer
<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Lymphoma
<input type="checkbox"/> Depression	<input type="checkbox"/> Prostate Cancer
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Radiation Treatment
<input type="checkbox"/> End Stage Renal Disease	<input type="checkbox"/> Seizures
<input type="checkbox"/> GERD	<input type="checkbox"/> Stroke
<input type="checkbox"/> Other	

Past Surgeries: (please check mark all past surgeries)

<input type="checkbox"/> None	<input type="checkbox"/> Other
<input type="checkbox"/> Appendix (Appendectomy)	<input type="checkbox"/> Kidney: Stone Removal
<input type="checkbox"/> Bladder (Cystectomy)	<input type="checkbox"/> Kidney: Transplant Date:
<input type="checkbox"/> Breast: Breast Biopsy R/L	<input type="checkbox"/> Kidney: Nephrectomy/Biopsy
<input type="checkbox"/> Breast: Lumpectomy B/R/L	<input type="checkbox"/> Liver: Hepatectomy/Shunt
<input type="checkbox"/> Breast: Mastectomy B/R/L Date:	<input type="checkbox"/> Liver: Transplant Date:
<input type="checkbox"/> Colon Cancer Resection Date:	<input type="checkbox"/> Ovaries (Oophorectomy): Endometriosis/Cancer/Cyst Date:
<input type="checkbox"/> Colon (Colectomy) Date:	<input type="checkbox"/> Ovaries: Tubal Ligation
<input type="checkbox"/> Colon: Colostomy Date:	<input type="checkbox"/> Pancreas: Pancreatectomy
<input type="checkbox"/> Gallbladder (Cholecystectomy)	<input type="checkbox"/> Prostate (Prostatectomy):
	<input type="checkbox"/> Prostate (Prostatectomy): TURP
<input type="checkbox"/> Heart: Valve Replacement	<input type="checkbox"/> Rectum:
<input type="checkbox"/> Heart: Bypass Surgery	<input type="checkbox"/> Skin : Biopsy/Surgery
<input type="checkbox"/> Heart: Heart Transplant	<input type="checkbox"/> Spleen (Splenectomy)
<input type="checkbox"/> Heart: PTCA	<input type="checkbox"/> Testicles (Orchiectomy)
<input type="checkbox"/> Joint Replacement: Hip/Knee - B/L/R Date:	<input type="checkbox"/> Uterus (Hysterectomy)

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Skin Disease History: (please check mark all the skin conditions that you have had)

<input type="checkbox"/> None	
<input type="checkbox"/> Acne	<input type="checkbox"/> Flaking or Itchy Scalp
<input type="checkbox"/> Actinic Keratoses	<input type="checkbox"/> Hay Fever/Allergies
<input type="checkbox"/> Asthma	<input type="checkbox"/> Melanoma
<input type="checkbox"/> Basal Cell Skin Cancer	<input type="checkbox"/> Poison Ivy
<input type="checkbox"/> Blistering Sunburns	<input type="checkbox"/> Precancerous Moles
<input type="checkbox"/> Dry Skin	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Eczema	<input type="checkbox"/> Squamous Cell Skin Cancer
<input type="checkbox"/> Other	

Do You Wear Sunscreen?

<input type="checkbox"/> Yes	<input type="checkbox"/> No – If yes what SPF?
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Do You Tan In a Tanning Salon?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Family History

Do You Have a Family History of Melanoma?

<input type="checkbox"/> Yes	<input type="checkbox"/> No – if yes Which Relative -
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Other Pertinent Family History (Only first degree relatives):

Medications: (please enter all current medications and dosages or attach a list)

None

Allergies: (please enter all allergies and reactions or attach a list)

None

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Social History: (please check all that apply)

Current Height: _____ Weight: _____ Occupation/Former Occupation: _____

Smoking Status:	<input type="checkbox"/> Never smoker
<input type="checkbox"/> Former Smoker Date Start/Quit:	<input type="checkbox"/> Current Every Day Smoker #Packs Per Day for how many years:
Alcohol Status:	
<input type="checkbox"/> none	<input type="checkbox"/> Less Than 1 Drink Per Day
<input type="checkbox"/> 1-2 Drinks Per Day	<input type="checkbox"/> 3 or More Drinks Per Day

What is your caffeine intake: _____

How often do you exercise: _____

<input type="checkbox"/> Patient Feels Safe at Home	<input type="checkbox"/> Patient Feels Unsafe at Home
<input type="checkbox"/> Patient Drives in the Daytime	<input type="checkbox"/> Patient Drives at Night

Review of Systems/Alerts: (please check all that apply)

<input type="checkbox"/> None
<input type="checkbox"/> Problems With Healing
<input type="checkbox"/> Hypertension
<input type="checkbox"/> Irregular Heart Beat
<input type="checkbox"/> Anxiety/Depression
<input type="checkbox"/> Ebola: Traveled To Country Ebola Transmission in the Last 21 Days, contact with Ebola Patient, Headaches, Weakness, Muscle Pain, Vomiting, Diarrhea,
<input type="checkbox"/> Rash
<input type="checkbox"/> Hay Fever
<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Fever or Chills
<input type="checkbox"/> Night Sweats
<input type="checkbox"/> Unintentional Weight Loss
<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Sore Throat
<input type="checkbox"/> Blurry Vision
<input type="checkbox"/> Abdominal Pain
<input type="checkbox"/> Bloody Stool
<input type="checkbox"/> Bloody Urine
<input type="checkbox"/> Joint Aches/Muscle Weakness
<input type="checkbox"/> Seizures
<input type="checkbox"/> Cough/Shortness of Breath/Wheezing

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Alerts: (please check all that apply)

<input type="checkbox"/> Allergy to Adhesive	<input type="checkbox"/> HIV
<input type="checkbox"/> Allergy to Local Anesthetic	<input type="checkbox"/> Hepatitis B or C
<input type="checkbox"/> Allergy to Latex	<input type="checkbox"/> MRSA
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Defibrillator or Pacemaker
<input type="checkbox"/> Artificial Joints Within Past 2 Years	<input type="checkbox"/> Oxygen Use (#liters/demand or continuous)
<input type="checkbox"/> Premedication Prior to Procedures	<input type="checkbox"/> Allergy to Topical Antibiotic Ointment
<input type="checkbox"/> Blood Thinners	<input type="checkbox"/> Rapid Heart Beat With Epinephrine
<input type="checkbox"/> Problems With Bleeding	<input type="checkbox"/> Pregnancy or Planning
<input type="checkbox"/> Problems With Scarring (hypertrophic or keloid)	
<input type="checkbox"/> Immunosuppression (transplant/chemotherapy/medication)	

Have you had your pneumonia vaccine? Yes No

Have you had your flu vaccine this year? Yes No