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)

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

Past Surgeries: (please check mark all past surgeries)

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

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

☐ None	
☐ Acne	☐ Flaking or Itchy Scalp
☐ Actinic Keratoses	☐ Hay Fever/Allergies
☐ Asthma	☐ Melanoma
☐ Basal Cell Skin Cancer	☐ Poison Ivy
☐ Blistering Sunburns	☐ Precancerous Moles
☐ Dry Skin	☐ Psoriasis
☐ Eczema	☐ Squamous Cell Skin Cancer
☐ Other	

Do You Wear Sunscreen?

☐ Yes	☐ No – If yes what SPF?

Do You Tan In a Tanning Salon?

☐ Yes	☐ No

Family History

Do You Have a Family History of Skin Cancer?

☐ Yes	☐ No – if yes what Type?	Which Relative?

Other Pertinent Family History (Only first degree relatives):

_____

_____

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

☐ None

_____

_____

_____

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Patient Name_____D.O.B____/____/____Today's Date_____

Social History: (please check all that apply)

Current Height: _____Weight: _____ Occupation/Former Occupation: _____

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

What is your caffeine intake: _____

How often do you exercise: _____

☐ Patient Feels Safe at Home	☐ Patient Feels Unsafe at Home
☐ Patient Drives in the Daytime	☐ Patient Drives at Night

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

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

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Alerts: (please check all that apply)

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

Have you had your pneumonia vaccine? □ Yes □ No

Do you get the flu vaccine? □ Yes □ No

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Medication List

Name:

Birth date:

Name of Medication	Dosage	How often

Reviewed: Date: