

**SOUTH CAROLINA SKIN CANCER CENTER**  
**James R. DeBloom, M.D.**  
**MEDICAL HISTORY FORM**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  M  F Date: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_

Reason for Today's visit:  Mohs  Checkup  other: \_\_\_\_\_ Referred by: \_\_\_\_\_

**History of today's problem only:**  No Problem today.

Skin areas involved: \_\_\_\_\_

How long has the problem been present: \_\_\_\_\_

Was a biopsy done?  No  Yes  biopsy done by referring doctor

**Was there any treatment?**  No  Yes When? \_\_\_\_\_ Type? \_\_\_\_\_

<u>Quality</u>	<u>Modifying Factors</u>	<u>Associated Symptoms</u>	<u>Severity</u>
A change in:	A history of:		
<input type="checkbox"/> size	<input type="checkbox"/> X-ray treatments	<input type="checkbox"/> bleeding	<input type="checkbox"/> no symptoms
<input type="checkbox"/> color	(not routine or chest x-ray)	<input type="checkbox"/> tingling	<input type="checkbox"/> occasional symptoms
<input type="checkbox"/> elevation	<input type="checkbox"/> UV light treatment	<input type="checkbox"/> pain	<input type="checkbox"/> constant symptoms
<input type="checkbox"/> hardness	<input type="checkbox"/> arsenic exp/ treatment	<input type="checkbox"/> ulceration	
	<input type="checkbox"/> chronic scar	<input type="checkbox"/> infection	
	<input type="checkbox"/> immunosuppression	<input type="checkbox"/> itching	
	<input type="checkbox"/> none	<input type="checkbox"/> none	

ALLERGIES to medications:  none  yes/list: \_\_\_\_\_

Current medications:  none  yes/list: \_\_\_\_\_

Aspirin/ blood thinners – last taken: \_\_\_\_\_

<u>Skin</u>	<u>Hematologic/Lymphatic</u>	<u>Constitutional Symptom</u>	<u>Eyes/Ears/Nose/Throat</u>
<input type="checkbox"/> <b>normal/ none</b>	<input type="checkbox"/> <b>normal</b>	<input type="checkbox"/> <b>none</b>	<input type="checkbox"/> <b>normal</b>
<input type="checkbox"/> abnormal scarring	<input type="checkbox"/> blood transfusions	<input type="checkbox"/> weight loss	<input type="checkbox"/> glaucoma
<input type="checkbox"/> poor healing/ scaling	<input type="checkbox"/> bleeding problems	<input type="checkbox"/> fever	<input type="checkbox"/> hearing aid
<input type="checkbox"/> other skin disorders:	<input type="checkbox"/> enlarged lymph nodes	<input type="checkbox"/> other: _____	<input type="checkbox"/> plastic surgery:

<u>Cardiovascular</u>	<u>Respiratory</u>	<u>Gastrointestinal</u>	<u>Musculoskeletal</u>
<input type="checkbox"/> <b>normal</b>	<input type="checkbox"/> <b>normal</b>	<input type="checkbox"/> <b>normal</b>	<input type="checkbox"/> <b>normal</b>
<input type="checkbox"/> angina	<input type="checkbox"/> asthma	<input type="checkbox"/> stomach ulcer	<input type="checkbox"/> arthritis
<input type="checkbox"/> artificial heart valve	<input type="checkbox"/> emphysema	<input type="checkbox"/> colitis	<input type="checkbox"/> artificial joint
<input type="checkbox"/> pacemaker	<input type="checkbox"/> other problems:	<input type="checkbox"/> other GI problems:	<input type="checkbox"/> other: _____
<input type="checkbox"/> hypertension			

<u>Neurological</u>	<u>Psychiatric</u>	<u>Endocrine</u>	<u>Infections</u>
<input type="checkbox"/> <b>normal</b>	<input type="checkbox"/> <b>normal</b>	<input type="checkbox"/> <b>normal</b>	<input type="checkbox"/> <b>none</b>
<input type="checkbox"/> stroke	<input type="checkbox"/> depression	<input type="checkbox"/> diabetes	<input type="checkbox"/> hepatitis
<input type="checkbox"/> seizures	<input type="checkbox"/> anxiety attacks	<input type="checkbox"/> thyroid	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> other:	<input type="checkbox"/> other:	<input type="checkbox"/> other:	<input type="checkbox"/> tuberculosis (TB)
			<input type="checkbox"/> other: _____

**Past History:**

Previous history of skin cancer:  none  yes/ list: location & date \_\_\_\_\_

Major illnesses or hospitalizations:  none  yes/list: \_\_\_\_\_

Organ transplant:  none  yes/list: \_\_\_\_\_

**Family History:**

Skin cancer:  none  basal cell  squamous cell  melanoma List: \_\_\_\_\_

**Social History: Occupation:** \_\_\_\_\_ **Marital Status:**  S  M  D  W

**Do you wear:**  Dentures  Glasses  Contact lenses **SMOKING:**  no  former  yes/packs per day \_\_\_\_\_

**Alcohol:**  no  social/ occasional drinking only **Alcohol or drug problems:**  none  describe \_\_\_\_\_

(For office use only) No other changes in ROS, Past, family & social history as of: \_\_\_\_\_

This information was obtained, reviewed for accuracy and confirmed by James DeBloom II, M.D.

Additional information is provided in dictation from this date.