PATIENT HISTORY
for
Grant Gerner, MD
Skin Cancer Medicine

Name:_____DOB:____/____/_____

Phone # (best # to reach you): _____-_____-_____ (circle) Cell Home Work Other:_____
May we leave a detailed message about test results at this #? (circle) YES NO
Alternate Phone #: _____-_____-_____ (circle) Cell Home Work Other:_____

email:_____
Person to Contact for Emergencies or if we are unable to reach you for reminders or results:

_____ Relationship: _____

Phone:_____ (circle) Cell Home Work Other:_____

Your Primary Care Provider:_____

Phone:_____ Did your PCP refer you here? (circle) YES NO

SKIN CANCER HISTORY:

Have you had skin cancer? YES NO
If so, what type(s) have you had? What year? Where on your body? What type of treatment?

Melanoma _____

Squamous Cell Carcinoma _____

Basal Cell Carcinoma _____

Other skin cancer _____

If you have had melanoma, who was the clinician that performed the biopsy? Their phone #?

_____
Have you had any atypical, pre-cancerous moles ("dyplastic nevi")? YES NO

If so, where on your body and when was the biopsy?_____

Have you had any other pre-cancerous skin growths ("actinic keratoses)"? YES NO

Have you had any topical treatments for sun damage/pre-cancers such as freezings, Efudex (5-FU), Aldara/Zyclara (imiquimod), photodynamic therapy (PDT via blue or red light), etc.? YES NO
If YES, what part of your body was treated and when?

_____

SKIN CANCER RISK FACTORS:

Do you have a relative who has had melanoma or pancreatic cancer? YES NO
If YES, which relative? (circle) Parent Sibling Child Other:_____

As a young adult, did you have more than 50 nevi ("moles")? YES NO
Do you use sunscreen? (circle) Routinely Occasionally Rarely Never What SPF:_____

Do you have a relative who has had a non-melanoma skin cancer? YES NO
If YES, which relative? (circle) Parent Sibling Child Other:_____

Do you have a suppressed immune system? YES NO
If YES, is this due to: (circle) Organ Transplant HIV Other, such as medication for rhematoid arthritis, psoriasis, MS:_____

Do you take or have you taken a thiazide diuretic, e.g. hydrochlorothiazide (HCTZ)? YES NO
Do you take or have you taken long-term tetracycline, doxycyline, or minocyline? YES NO

Have you ever had a severe sunburn that caused painful blisters (not just peeling)? YES NO
If YES, how many times and at what age?_____

Have you used a tanning bed or tanning lamp? YES NO
If YES, approximately how many times and at what age?_____

Have you ever been a sunbather? YES NO
If YES, for how many years?_____, (circle) rarely occasionally frequently

Have you ever had outdoor work or have you been a glass blower? YES NO
If YES, what type of work and for how many years?_____

Have you spent much time on water? YES NO
If YES, what activity and how many years?_____

Have you had outdoor hobbies or sports? YES NO
If YES, what activities and how many years?_____

Have you ever had any radiation treatments? YES NO
If YES, what part of your body and when?_____

Have you ever worked with harsh chemicals or arsenic on unprotected skin? YES NO
If YES, what chemicals and how often?_____

What best describes your skin type (circle the numeral):

I. Very fair, pale skin. Always sunburns. Unable to tan.
II. Fair, pinkish-red toned skin. Sunburns easily. Tans slightly.
III. Olive shaded skin. Occasionally sunburns. Tans gradually, moderately.
IV. Darker, tawny or light brown skin tones. Minimally sunburns. Always tans well.
V. Moderately dark brown skin. Rarely sunburns. Tans very deeply.
VI. Very dark brown, deeply pigmented skin. Never sunburns. Becomes even darker from the sun.

SURGICAL RISKS: (check all that apply)

_____Allergic to bandages, tapes, adhesives
_____Allergic to Aquaphor or lanolin
_____Allergic to local anesthetics such as lidocaine
_____Rapid heartbeat with epinephrine
_____Artificial Heart Valve, if YES, mechanical or biological?_____
_____Artificial Joint, if YES, where?_____, year placed?_____
_____Require antibiotics prior to dental work or surgery
_____Take any blood thinner including aspirin
_____Have you ever had MRSA (multi-drug resistant Staphylococcus aureus) infection
_____Have a pacemaker or defibrillator
_____Pregnant or attempting pregnancy
_____Faint in response to blood or needles
_____Poor or prolonged wound healing
_____Gammaglobulin deficiency
_____Scar badly from minor wounds/procedures (keloids or hypertrophic scars)

Past Medical History (circle all that apply)

Anxiety	Stroke	Prostate Cancer
Depression	Circulation Problems	Lung Cancer
Bipolar	Atrial Fibrillation	Leukemia/Lymphoma/Myeloma
Schizophrenia	Diabetes	Asthma
Seizure Disorder	High Blood Pressure	COPD
Parkinson's Disease	High Cholesterol	Sleep Apnea
Dementia	Breast Cancer	Low Thyroid
Heart Attack	Colon Cancer	High Thyroid

Other:_____

_____

_____

Medications (please list medication and dosage or supply a separate list):

_____

_____

_____

_____

_____

Allergies or Reactions to Medication:_____

_____

Past Surgical History (circle all that apply)

Appendectomy
Mastecectomy (right, left, both)
Breast Implants
Breast Reduction
Colectomy for Colon Cancer
Colectomy for non-cancerous condition
Gallbladder Removal
Coronary Artery Bypass (CABG)
Coronary Artery Stent
Heart Valve (mechanical or biological)
Joint Replacement (list which and when below)
Kidney Removal (nephrectomy)
Kidney Stone removal/destruction (lithotripsy)
Organ Transplant (list which and when below)
Hysterectomy for cancer
Hysterectomy for non-cancerous condition
Ovaries removed for cancer
Ovaries remove for non-cancerous condition
Prostate Surgery (list reason below)
Spleen Removed
Testicles Removed
List Any Other Surgeries Below

_____

_____

_____

Social History

(circle) Single Married Widowed Divorced Domestic Partner/Significant Other

Name of Spouse/Partner/Other:_____

Children:_____

Occupation:_____

What city do you live in:_____since:_____

Residence in childhood:_____

Other Residences:_____

Hobbies & Sports, current and past:_____

_____

Smoking History: (circle) Never Current Past

#of years smoked:_____ average # packs/day:_____year quit smoking:_____

Alcohol Use: (circle) None <1 drink/day 1-2 drinks/day 3 or more drinks/day (on average)