GRANT GERNER, MD

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NEW PATIENT HISTORY

Name:_____ DOB: _____

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

May we leave a detailed message about lab results at the above #? (circle) **YES** **NO**

Alternate Phone #: _____-_____-_____ (circle) Cell Home Work Other: _____

email: _____

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

Name of Spouse/Partner/Other: _____

Spouse/Partner/Other Phone #: _____-_____-_____

Person to contact for emergencies or if we are unable to reach you for reminders or results:

_____ Relationship: _____

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

MEDICAL HISTORY

(Please list any current or past medical conditions or diagnosis, eg high blood pressure, diabetes, high cholesterol etc.)

_____

_____

_____

_____

PAST SURGICAL HISTORY

(Please list any major surgeries)

_____

_____

_____

_____

SKIN CANCER HISTORY

Have you had skin cancer? **YES** **NO**

If YES, which have you had:

Melanoma: Body location: _____ Year diagnosed: _____

Squamous Cell Carcinoma: Body location: _____ Year diagnosed: _____

Basal Cell Carcinoma: Body location: _____ Year diagnosed: _____

Other Skin Cancer: Body location: _____ Year diagnosed: _____

If you have had melanoma, who was the clinician that performed the biopsy? _____

Have you had any atypical, pre-cancerous moles (dysplastic nevi)? **YES** **NO**
If YES, where on your body and when was the biopsy? _____

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

Have you had any topical treatments for pre-cancers (AKs) or sun damage? **YES** **NO**
(check all that apply):
___Freezings ____Efudex (5-FU, 5-Fluorouracil) ___Aldara/Zyclara (imiquimod)
___Photodynamic therapy (PDT) with blue or red light Other: _____

If YES, what part of your body was treated and when? _____

SKIN CANCER RISK FACTORS

Has any immediate relative had melanoma? **YES** **NO**
If YES, which relative? (circle any that apply) Mother, Father Sister, Brother, Daughter, Son

As a young adult (under age 50), did you have more than 50 moles (nevi)? **YES** **NO**

Do you have a suppressed immune system? **YES** **NO**
If YES, is this due to: (circle) organ transplant, HIV, other: (such as medication for rheumatoid arthritis, psoriasis, MS): _____

Do you take or have you taken a thiazide diuretic, e.g. hydrochlorothiazide (HCTZ)? **YES** **NO**
If YES, approximately how many years? _____

Do you take or have you taken long-term tetracycline, doxycycline, or minocycline? **YES** **NO**

Do you use sunscreen? **YES** **NO**
How often? Routinely Occasionally Rarely
What SPF? _____

Have you ever been a sunbather? **YES** **NO**
If YES, for how many years? _____

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 worked outdoors? **YES** **NO**
If YES, what type of work and for how many years? _____

Have you spent much time on water (i.e. boats, surfing, etc)? **YES** **NO**
If YES, what activity and how many years? _____

Have you ever had any radiation treatments (i.e. for treating cancer or acne, etc)? **YES** **NO**
If YES, what part of your body and when? _____

Have you ever been a glass blower? **YES** **NO**
If YES, for how many years? _____

MEDICATIONS (please list all current medications or supply a separate list)

_____
_____
_____

MEDICATION ALLERGIES OR REACTIONS TO MEDICATION

_____
_____

SMOKING HISTORY (circle one) Never Current Past

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

SOCIAL HISTORY (circle one)

What city do you currently live in?: _____

Residence in childhood: _____

Other residences: _____

Occupation (current and past): _____

Do you have children? **YES** **NO** How many? _____

Hobbies and sports (current and past): _____

_____

CURRENT SYMPTOMS (check all that apply)

___Unexplained weight loss
___Chronic cough or shortness of breath
___Swollen or enlarged lymph glands
___Wounds bleed excessively
___Heart issues/chest pain
___Ever had seizures
___Anxiety
___NONE OF THE ABOVE
___New or unusual headache
___New or unusual abdominal pain
___Recent change in vision
___Suppressed immune system
___Fever/Chills/Night sweats
___Wheezing
___Depression

SURGICAL RISKS (check all that apply)

____Allergic to bandages, tapes, adhesives
____Allergic to Aquaphor or lanolin
____Allergic to local anesthetics such as lidocaine
____Allergic to topical antibiotics (e.g. Neosporin)
____Rapid heartbeat with epinephrine
____Artificial heart valve, if YES, mechanical or biological? _____
____Artificial joint, if YES, which joint? _____ year re-placed? _____
____Require antibiotics prior to dental work or surgery
____Take any blood thinners including aspirin
____Have you ever had a MRSA (multi-drug resistant staphylococcus aureus) infection
____Have a pacemaker or defibrillator
____[Women Only] Pregnant or attempting pregnancy
____Faint in response to blood or needles
____Poor or prolonged wound healing
____Scar badly from minor wounds/procedures (keloids or hypertrophic scars)
____Get wound infections easily or frequently
____Have a gamma globulin deficiency
____NONE OF THE ABOVE