



## **DERMATOLOGY** A Department of Aspirus Wausau Hospital

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Compassion for people.

## **Medical History and Review of Systems**

Date					
Patient Name	<u> </u>		Accoun	tD	ate of Birth
Height	Weight	Male Female			
<b>Current Medications and Doses</b>			Medi	cations	Dosage
	mins, pain medications, herbals, c escription meds.)	or			
I —	s box if you are not taking any m	nedication	, vitamins,	herbals, supple	nents or other non-
	ion medications.				
If yes, to wh	any allergies? ( <i>Please include allei</i> nat?	-	_	<del>_</del>	
	he reaction you had?				
Do you have	a sensitivity to latex? No	Yes			
Personal/Soc Do you smoke Do you drink	e?	☐ No	☐ Yes	=	h? h?
Are you breas	ing on becoming pregnant soon? tfeeding?	No No	☐ Yes ☐ Yes ☐ Yes		due date
are you using	contraception?	☐ No	Yes	If yes, what?	



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## **MEDICAL HISTORY AND REVIEW OF SYSTEMS**

What is your occupation?	Has anyone in your family had melanoma?			
If retired, what was your occupation?	☐ No ☐ Yes			
Have you ever had skin cancer?  No Yes	Yes, who?			
If yes, what type?	(If grandparent, aunt or uncle, please specify if they are maternal or paternal)			
What year?				
What treatment did you have?	Do you have a history of cancer? No Yes			
Who was the doctor that treated you?	If yes, what type?			
Clinic name and phone number:	What type of treatment did you have? Please circle all that apply:			
Have you had an atypical nevus, dysplastic mole, or	Surgery Chemotherapy Radiation			
Clark's Nevus? No Yes	Do you have a history of organ transplant?			
If yes, what type?	☐ No ☐ Yes			
What year?	If yes, what organ?			
What treatment did you have?	If yes, what year?			
Who was the doctor that treated you?	Do you have a history of immunosuppression? ☐ No ☐ Yes			
Clinic name and phone number:	What is the cause of immunosuppression (medication, disease, etc.)?			
Have you had radiation exposure or treatment?  No Yes	What year did you start immunosuppression?			
Do you have a history of any specific skin disease?				
☐ No ☐ Yes If Yes, please list:				
Do you have any other disease, condition  No Yes If yes, please list	or problem that Doctor should know about?			
Form Completed by:	DateTime			
If other than patient, list relationship				
************	**********			
FOR OFFI	CE USE ONLY			
Reviewed by	DateTime			