MEDICAL HISTORY
Waccamaw Dermatology and Plastic Surgery LLC

Please answer all of the questions as accurately as possible. Please turn this sheet over and fill in the information on the back. Bring this form in with you to your appointment (DO NOT MAIL).

Last Name, First _____ RECORD # _____ Date_____
How were you referred to us? _____
Why were you referred to us? _____
What is your Age _____ Sex: _____ M _____ F
Who is your Primary Care Doctor? _____
If you have a Cardiologist what is His / Her name? _____
Were you born in the South or lived here over 10 years? Y / N
Did you ever live on a farm? Y / N
Did you ever live on / or near the beach? Y / N
Did you spend a lot of time around water activities (Swim/Beach/Fishing/Boating/Sun Bathing/Golf)? Y /N
Did you have any blistering sunburns ever? Y / N
Do you have a family history of skin cancer? Y / N
Did you ever work outdoors? Y / N

What is or was your Occupation? _____ Are you retired? Y / N
Which hand is your dominant one? Right____ Left ____ Use Both Equally _____
Do you have any Hobbies or Talents? Y / N What are they? _____
What is your Weigh in pounds? _____ What is your Height ____' ____"

What are your DRUG ALLERGIES? _____ ____I have NO known drug allergies
Drug Name _____ Effect _____
Drug Name _____ Effect_____

What are the MEDICATIONS YOU TAKE? _____ I take NO Medications at all.
Drug Name _____ Drug Name _____
Drug Name _____ Drug Name _____
Drug Name _____ Drug Name _____
Drug Name _____ Drug Name _____
Do you take aspirin or Ibuprofen daily or almost every day? Y / N

Have you previously had skin cancer? Y / N
_____ Basal Cell _____ Squamous Cell _____Melanoma

WHAT ARE YOUR PREVIOUS SURGERIES, MAJOR ILLNESSES, AND HOSPITALIZATIONS?
_____ I have never had any type of surgery, ever.
_____ Date _____
_____ Date _____
_____ Date _____

******YOU ARE RESPONSIBLE FOR COMPLETING THIS FORM**
WDPS, LLC AND ITS EMPLOYEES ARE NOT RESPONSIBLE FOR PROBLEMS ARISING FROM YOUR ERRORS OR OMISSIONS****

Last Name, First _____ Record# _____ Date _____

FAMILY HISTORY: Have any immediate family members had? (Circle)

Breast Cancer Melanoma Heart Disease Diabetes Bleeding Problems Anesthesia Problems

What age did your mother die? _____ What did she die from? _____
What medical problems did she have? _____
What age did your father die? _____ What did he die from? _____
What medical problems did he have? _____

YOUR OWN PAST MEDICAL HISTORY: Have you had? (Circle or fill in blank)

Heart Disease	Stroke	Rheumatic Fever	Anemia	Asthma
Diabetes	Tuberculosis	Glaucoma	Arthritis	Seizures
AIDS or HIV+	Hepatitis	Chemical Dependency	Bleeding Tendency	
Stomach Ulcer	Kidney Disease	Thyroid Disease	Heart Valve Disease	
Liver Disease	Depression	Anxiety	Psychiatric or Nervous Illness	
High Blood Pressure				

Cancer / Type: _____
OTHER _____

REVIEW OF HEALTH SYSTEMS: Do you have now or had within the past year? (Circle)

Weigh Change	Dry Eyes	Skin Rash / Lesions	Shortness of Breath
Chronic Cough	Chest Pain	Rapid Heart Beat	Chronic Diarrhea
Easy Bleeding	Easy Bruising	Swollen Feet / Ankle	Diarrhea
Dizziness	Tremors	Weakness	Nausea Vomiting
Constipation	Fever	Malaise	Voiding Problems
Unusual Weigh loss or gain		Skin Lesions (lesions/marks/scars/lumps/tenderness)	
Difficulty sleeping / staying awake / or thinking clearly			

WOMEN ONLY:
Date of Last Period _____Number of Pregnancies _____ Date Last Mammogram _____
Do you do regular breast self-examinations? Yes/No Do you have any breast lumps or discharge? Yes / No
Is there any reasonable chance you are pregnant? Yes / No

SOCIAL HISTORY:
Were you ever a smoker? Yes / No How many years did you smoke in total? _____
If so, at the most how many packs per day did you smoke?_____
If you quit how many years ago did you do so? _____
Do you drink any alcohol almost daily? Yes / No If so how many drinks per day? _____
Do you use any illicit substances (ILLEGAL DRUGS) or have had significant exposure to chemicals at work? Yes / No What are they?_____

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE:

Signature of Patient or Guardian: _____ Date _____/_____/__

Signature of Medical Provider: _____

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