

PLEASE COMPLETE THE FOLLOWING MEDICAL HISTORY FORM

Name _____ Date _____ Age _____ Sex _____ Ht _____ Wt _____
Referring Doctor _____ Primary Care Doctor _____
Do you have an advanced directive/living will? Yes No
Preferred pharmacy: Yes _____ No (will send to Concord Pharmacy in building)

Reason for today's visit:

History of today's problem(s):

Skin areas involved:

How long has the problem been present?

Was a biopsy done? No Yes **Who did the biopsy?** Referring MD Other _____

Any previous treatment? No Yes **What was done and when?** _____

Previous skin cancer? No Yes **Previous Mohs surgery?** No Yes _____

Check all that apply regarding today's problem: None Apply

CHANGE IN: Size Color Elevation Hardness

HISTORY OF: Bleeding Tingling/itching Pain Ulceration Infection Occasional symptoms Constant symptoms

RISK FACTORS: X-ray treatments (not routine X-rays) UV light treatments Arsenic exposure Immunosuppression

PLEASE LIST ALL MEDICATIONS, DOSAGES, & FREQUENCY (Including vitamins, herbs and supplements)

MEDICATION ALLERGIES: None List with reaction:

LATEX ALLERGY: Yes No

Check ALL that apply regarding your overall health and add any other medical problems:

CARDIOVASCULAR

- Normal
- Artificial valve
- Pacemaker
- High blood pressure
- Heart Attack (when?)
- High Cholesterol
- Bypass/other surgery
- Mitral valve prolapse
- Other heart problem

NEUROLOGICAL

- Normal
- Stroke
- Seizures
- Alzheimer's
- Parkinson's

RESPIRATORY

- Normal
- Emphysema
- Asthma

INFECTIONS

- Normal
- Hepatitis
- HIV/AIDS
- Tuberculosis
- MRSA

ENDOCRINE

- Normal
- Diabetes
- Thyroid problem

MUSCULOSKELETAL

- Normal
- Arthritis
- Fibromyalgia
- Artificial joint – date installed:

PSYCHIATRIC

- Normal
- Depression
- Anxiety disorder
- Other

SKIN (besides skin cancer)

- Normal
- Poor/slow healing
- Keloids

GASTROINTESTINAL

- Normal
- Stomach Ulcer
- Colitis
- Irritable bowel
- Reflux

BLOOD/LYMPH

- Normal
- Enlarged lymph nodes
- Anemia
- Bleeding problems

GENERAL

- Normal
- Fever/Weight loss

HEAD/NECK

- Normal
- Hearing aid
- Glaucoma
- Plastic surgery

OTHER MEDICAL PROBLEMS: _____

MAJOR ILLNESSES/HOSPITALIZATIONS: none List: _____

FAMILY HISTORY: Melanoma Other skin cancers Bleeding Problems

Other medical problems: _____

Occupation: _____ **Marital status:** S M D W

Do you wear: Dentures Glasses Contacts

Smoking: No Former Yes; packs per day? _____

Alcohol: No Social/occasional drinking **Number of drinks/day** _____

How many times have you had 5 (men) or 4 (women) or more drinks in a day in the past year? _____

Alcohol or drug problems/addictions: No Yes (please describe) _____

Have you had a flu shot in the past year? No Yes **Have you ever had the pneumonia vaccine?** No Yes

BAUCOM & MINA DERM SURGERY, LLC

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PATIENT DEMOGRAPHIC INFORMATION

Date: _____ Updated: _____ Updated: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

County: (circle or write in): Cherokee Cobb Dekalb Fayette Forsyth Fulton Gwinnett Hall Henry
Other: _____

Race/Ethnic Group (circle one): Hispanic Non-Hispanic Other _____ Prefer not to answer

Preferred language (if other than English): _____

Phone# Home: _____

Work: _____

Cell: _____

Date of Birth: _____ Social Security Number: _____

Email Address: _____

Preferred Pharmacy: _____ Phone #: _____

** Emergency Contact: _____

Phone: _____

Relationship to Patient: _____