

Jason P. Hansen, MD

Dermatologic/Mohs Surgery
Intermountain Memorial Clinic



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Last Name _____ First Name _____ MI ____ Date _____

* Using a black pen, please complete and check all that apply and bring with you to your appointment *

<u>SKIN</u>	<u>MUSCULOSKELETAL</u>	<u>NEUROLOGICAL</u>	<u>CARDIOVASCULAR</u>
<input type="checkbox"/> None of the below	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal
<input type="checkbox"/> basal cell carcinoma	<input type="checkbox"/> arthritis	<input type="checkbox"/> seizure (epilepsy)	<input type="checkbox"/> chest pain or heart attack
<input type="checkbox"/> squamous cell carcinoma	<input type="checkbox"/> muscle weakness	<input type="checkbox"/> CNS shunt	<input type="checkbox"/> endocarditis
<input type="checkbox"/> melanoma	<input type="checkbox"/> fibromyalgia	<input type="checkbox"/> numbness/tingling	<input type="checkbox"/> artificial heart valve
<input type="checkbox"/> abnormal scarring/keloids	<input type="checkbox"/> artificial joints	<input type="checkbox"/> stroke	<input type="checkbox"/> high blood pressure
<input type="checkbox"/> other _____	<input type="checkbox"/> other _____	<input type="checkbox"/> other _____	<input type="checkbox"/> other _____
<u>RESPIRATORY</u>	<u>GASTROINTESTINAL</u>	<u>HEMATOLOGIC/LYMPHATIC</u>	<u>EYE/EAR/NOSE/THROAT</u>
<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal
<input type="checkbox"/> asthma	<input type="checkbox"/> stomach ulcer	<input type="checkbox"/> anemia	<input type="checkbox"/> glaucoma
<input type="checkbox"/> emphysema	<input type="checkbox"/> colitis	<input type="checkbox"/> bleeding problems	<input type="checkbox"/> hearing aid
<input type="checkbox"/> cough	<input type="checkbox"/> liver problems	<input type="checkbox"/> cancer/enlarged nodes	<input type="checkbox"/> plastic surgery
<input type="checkbox"/> other _____	<input type="checkbox"/> other _____	<input type="checkbox"/> other _____	<input type="checkbox"/> other _____
<u>PSYCHIATRIC</u>	<u>ENDOCRINE</u>	<u>INFECTIONS</u>	<u>GENITOURINARY</u>
<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal
<input type="checkbox"/> depression	<input type="checkbox"/> diabetes	<input type="checkbox"/> hepatitis (circle) A B C	<input type="checkbox"/> dialysis/dialysis fistula
<input type="checkbox"/> anxiety	<input type="checkbox"/> thyroid	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> kidney problems
<input type="checkbox"/> dementia	<input type="checkbox"/> oral steroid use	<input type="checkbox"/> tuberculosis	<input type="checkbox"/> venereal disease
<input type="checkbox"/> other _____	<input type="checkbox"/> other _____	<input type="checkbox"/> other _____	<input type="checkbox"/> other _____
<u>ALLERGIC/IMMUNOLOGIC</u>	<u>CONSTITUTIONAL</u>	Have you read the Mohs Surgery Brochure? Y / N	
<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	Are you pregnant, planning pregnancy, or nursing? Y / N	
<input type="checkbox"/> lupus	<input type="checkbox"/> current weight _____ lbs	Are you allergic to latex or rubber? Y / N	
<input type="checkbox"/> organ transplant	<input type="checkbox"/> fever	Have you ever had radiation or UV treatments? Y / N	
<input type="checkbox"/> cancer chemotherapy	<input type="checkbox"/> chills	Have you had anesthesia complications? Y / N	
<input type="checkbox"/> other _____	<input type="checkbox"/> unintentional weight loss	Do you have a pacemaker or defibrillator? Y / N	
<u>MEDICATIONS (include doses and over the counter)</u>		<u>HOSPITALIZATIONS/ILLNESSES/SURGERIES</u>	
<u>ALLERGIES (list reactions)</u>	<u>FAMILY HISTORY</u>	<u>SOCIAL HISTORY</u>	
	<input type="checkbox"/> basal cell carcinoma	Occupation _____	
	<input type="checkbox"/> squamous cell carcinoma	Tobacco use Y / N	
	<input type="checkbox"/> melanoma	Alcohol use Y/N	

Reviewed	Date								
	Initials								