THE CENTER FOR Skin Cancer SURGERY

Health History Questionnaire

Name: _____ Age: _____ Date of Birth: _____

Address: _____ Nickname: _____

_____ Today's Date: _____ Gender:_____

Home Phone: _____ Cell Phone: _____ Referred By: _____

Current Complaint/Illness (please describe): _____

_____ E-Mail Address: _____

Current Adult Medical Conditions

(i.e. high blood pressure, diabetes, etc.) Date

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Previous Surgeries Date

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Social History

Current Tobacco Use: ◯ YES ◯ NO

Current Alcohol Use: ◯ YES ◯ NO

	Amount	Duration
Cigarettes:	_____	_____
Pipe/Cigar:	_____	_____
Chewing:	_____	_____
Alcohol:	_____	_____

Medical Allergies

_____

_____

_____

_____

_____

_____

_____

Current Medications with Dosage

_____

_____

_____

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