John D. Boyer, M.D. / Patrick M. Ellison, MD
MOHS MICROGRAPHIC SURGERY & DERMATOLOGIC SURGERY
1329 Lusitana Street Suite 501 Honolulu, HI 96813

MEDICAL HISTORY

Date:_____

Patient Name:_____ **Date of Birth:_____**

Reason for initial visit: _____ **Home Phone #:_____**

Are you ALLERGIC to any medication? ☐ YES ☐NO If Yes, please list on attached sheet

MEDICATION & SUPPLEMENTS you are currently taking: ☐NONE if any, please list on attached sheet

Past Medical History/Review Systems: (Do you currently have OR have you ever had any of the following-Give details). FILL OUT COMPLETELY IN BLACK PEN. IF NO PROBLEMS IN A PARTICULAR SYSTEM, CHECK NORMAL.

SKIN
- ☐ **None of the below problems**
- ☐ Precancer (Actinic Keratosis)
- ☐ Basal Cell Carcinoma
- ☐ Squamous Cell Carcinoma
- ☐ Dysplastic moles
- ☐ Blistering sun burns
- ☐ Abnormal scarring/keloids
- ☐ Tanning bed use
- ☐ Melanoma - **date:_____**
  Body location:_____

MUSCULOSKELETAL
- ☐ **Normal**
- ☐ Arthritis
- ☐ Limb swelling
- ☐ Fibromylagia
- ☐ Artificial joints
  -R / L hip date _____
  - R / L knee date____
  - other date_____

NEUROLOGICAL
- ☐ **Normal**
- ☐ Seizure / Epilepsy
- ☐ Neuralgia / nerve pain
- ☐ Numbness / Tingling
- ☐ Stroke or Paralysis
- ☐ Other_____

CARDIOVASCULAR
- ☐ **Normal**
- ☐ Chest pain
- ☐ Heart attack
- ☐ Pacemaker
- ☐ Heart valve problem
- ☐ High blood pressure
- ☐ Irregular heart rate
- ☐ Other_____

RESPIRATORY
- ☐ **Normal**
- ☐ Asthma / Emphysema
- ☐ Oxygen use:_____ **L/min**
- ☐ Cough
- ☐ Pneumonia shot **Y / N**

GASTROINTESTINAL
- ☐ **Normal**
- ☐ Stomach ulcer
- ☐ Change in bowel
- ☐ Liver problems / Jaundice
- ☐ Other_____

HEMATOLOGIC/LYMPHATIC
- ☐ **Normal**
- ☐ Anemia
- ☐ Bleeding problems
- ☐ Cancer/ enlarged lymph nodes
- ☐ Other _____

EYE/EAR/NOSE/THROAT
- ☐ **Normal**
- ☐ Glaucoma
- ☐ Hearing aid
- ☐ Plastic surgery____
- ☐ Cataracts/ Other__

PSYCHIATRIC
- ☐ **Normal**
- ☐ Depression/☐Anxiety
- ☐ Dementia
- ☐ Other_____

ENDOCRINE
- ☐ **Normal**
- ☐ Diabetes / ☐ Thyroid
- ☐ Oral steroid use
- ☐ Other_____

INFECTIONS
- ☐ **Normal**
- ☐ Hepatitis (circle)
  A or B or C
- ☐ HIV / AIDS/ TB
- ☐ History of Staph

GENITOURINARY
- ☐ **Normal**
- ☐ Dialysis
- ☐ Kidney problems
- ☐ Other_____

IMMUNOLOGIC
- ☐ **Normal**
- ☐ Lupus
- ☐ Organ transplant
- ☐Cancer chemotherapy

CONSTITUTIONAL
- ☐ **Normal**
- ☐***Current weight_____**
- ☐ Fever
- ☐ Chills
- ☐ Weight loss
- ☐ **Height_____**

Do you have any other MEDICAL PROBLEMS we should know about?
_____
_____
Major surgeries? _____
_____

Family History (blood relatives only—List relationship to you):
Please Check and Give Details
- ☐ **No family history of skin cancer or other skin problems**
- ☐ **Basal cell carcinoma/Squamous cell carcinoma _____**
- ☐**Melanoma_____**
- ☐ **Other skin problems _____**

Do you smoke? ☐Yes ☐No
Drink Alcohol? ☐Yes ☐No

Please sign: _____

_____
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Revised 12/16

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MEDICATIONS AND ALLERGIES LIST

ALLERGIES **Please list ALL medication/anesthetic/latex/adhesive allergies**	**REACTION (describe reaction—e.g. shock, rash, etc)**

MEDICATIONS: PLEASE LIST ALL PRESCRIBED MEDICATIONS AND DOSAGE

Name of Medication	**Dosage**	**Frequency**	**Reason**

Patient Name:_____ DOB: _____

_____
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