

**Saint Luke's Hospital**  
**Kansas City, MO 64111**  
**Saint Luke's Dermatology and Plastic Surgery**

**NEW VISIT – PLEASE COMPLETE THE FOLLOWING MEDICAL HISTORY FORM**

Describe your reason for this visit: \_\_\_\_\_

Current Medications \_\_\_\_\_

Allergies \_\_\_\_\_

Patient referred by: \_\_\_\_\_

**SYSTEM REVIEW: Check all that apply regarding your health & other important problems**

**Skin**

- normal
- abnormal scarring
- other \_\_\_\_\_

**Cardiovascular**

- normal
- angina
- artificial heart valve
- pacemaker
- hypertension
- heart attack

**Neurological**

- normal
- stroke
- seizures
- other \_\_\_\_\_

**Hematologic / Lymphatic**

- normal
- anemia
- bleeding problems
- enlarged lymph nodes

**Respiratory**

- normal
- asthma
- emphysema
- other \_\_\_\_\_

**Psychiatric**

- normal
- depression
- anxiety
- other \_\_\_\_\_

**Constitutional**

**Symptoms**

- none
- weight loss
- fever
- other \_\_\_\_\_

**Gastrointestinal**

- normal
- ulcer
- colitis
- liver problem
- other \_\_\_\_\_

**Endocrine**

- normal
- diabetes
- thyroid
- kidney
- other \_\_\_\_\_

**Eyes/Ears/Nose/Throat**

- normal
- glaucoma
- hearing aid
- other \_\_\_\_\_

**Musculoskeletal**

- normal
- arthritis
- artificial joint
- other \_\_\_\_\_

**Infection**

- none
- hepatitis
- HIV/AIDS
- tuberculosis/TB
- other \_\_\_\_\_

**PAST HISTORY:** Previous skin cancer:  None  Melanoma  Basal Cell  Squamous Cell  
 Location: \_\_\_\_\_ When: \_\_\_\_\_

**Do you have history of:**  X-Ray treatment  UV Light treatment  Arsenic exposure  
 Immunosuppression  Chronic scars

**FAMILY HISTORY:** Previous skin cancer:  None  Melanoma  Basal Cell  Squamous Cell

**SOCIAL HISTORY:** Occupation \_\_\_\_\_ Smoking:  Yes  No  Previous  
 Alcohol:  Yes  No  Occasional Drug Problem:  Yes  No

Previous Sunburns:  No  Mild  Moderate  Extensive

Are you using tanning beds?  Yes  No  Previously / Sunscreen?  Yes  No  Occasional

**DO NOT WRITE BELOW THIS AREA**

	Duration	Location	Change	Symptoms	Severity	Timing	Context
Problem #1			<input type="checkbox"/> size <input type="checkbox"/> color <input type="checkbox"/> elevation <input type="checkbox"/> other <input type="checkbox"/> no	<input type="checkbox"/> none <input type="checkbox"/> occasionally <input type="checkbox"/> constant	<input type="checkbox"/> bleeding <input type="checkbox"/> pain <input type="checkbox"/> ulceration <input type="checkbox"/> itching <input type="checkbox"/> infection <input type="checkbox"/> other	prior tx: <input type="checkbox"/> yes <input type="checkbox"/> no when: _____ type: _____	biopsy done: <input type="checkbox"/> yes <input type="checkbox"/> no  by whom: _____
Spot							
Rash							
Problem #2			<input type="checkbox"/> size <input type="checkbox"/> color <input type="checkbox"/> elevation <input type="checkbox"/> other <input type="checkbox"/> no	<input type="checkbox"/> none <input type="checkbox"/> occasionally <input type="checkbox"/> constant	<input type="checkbox"/> bleeding <input type="checkbox"/> pain <input type="checkbox"/> ulceration <input type="checkbox"/> itching <input type="checkbox"/> infection <input type="checkbox"/> other	prior tx: <input type="checkbox"/> yes <input type="checkbox"/> no when: _____ type: _____	biopsy done: <input type="checkbox"/> yes <input type="checkbox"/> no  by whom: _____
Spot							
Rash							
Problem #3			<input type="checkbox"/> size <input type="checkbox"/> color <input type="checkbox"/> elevation <input type="checkbox"/> other <input type="checkbox"/> no	<input type="checkbox"/> none <input type="checkbox"/> occasionally <input type="checkbox"/> constant	<input type="checkbox"/> bleeding <input type="checkbox"/> pain <input type="checkbox"/> ulceration <input type="checkbox"/> itching <input type="checkbox"/> infection <input type="checkbox"/> other	prior tx: <input type="checkbox"/> yes <input type="checkbox"/> no when: _____ type: _____	biopsy done: <input type="checkbox"/> yes <input type="checkbox"/> no  by whom: _____
Spot							
Rash							

Date of Today's Visit: \_\_\_\_\_ Nurses Notes & Signature \_\_\_\_\_

Physician signature: \_\_\_\_\_