Atrium Health

Patient Form: Skin History

Please fill out the information below. If you have any questions, please let us know and we will be happy to help you.

Name: _____ Date of Birth: _____

Primary Care Doctor (main doctor): _____

Doctor who referred (sent) you to our office: _____

What Brought You in Today:

Have you had a biopsy (tissue sample) for this area on your skin? _____ Yes _____ No If yes, what were the results? _____

What kind of changes have you seen in this spot?

___ Bleeding ___ Getting bigger ___Itching/Irritated

___ Color change ___ Other

How long has this mole/lump/sore been on your skin? _____

Have you had this area treated? _____ Yes _____ No If yes, how was it treated? _____

Have you had any other skin cancers? _____ Yes _____ No If yes, what? _____
When? _____ How was it treated? _____

Tell us about yourself:

Are you allergic to anything such as medicines or foods? _____ Yes _____ No If yes, what are you allergic to?
_____

Do you smoke or use nicotine products? _____ Yes _____ No If yes, what do you use and how much do you use each day? _____

Has any member of your family ever had skin cancer? _____ Yes _____ No If yes, who was it and what kind of cancer did they have?_____

Have you ever used a tanning bed? _____ Yes_____ No If yes, how often did you use it and how long did you go? _____

Patient Label

When you are in the sun do you:
___ burn only ___burn then tan ___tan but hardly ever burn ___tan, don't burn at all

Have you ever had a burn so bad you got blisters? _____ Yes _____ No If yes, how many times? _____

Have you or do you work outside? _____ Yes _____ No If yes, how long have you worked outside? _____

Do you or have you spent a lot of time in the sun for fun activities? _____ Yes_____ No If yes, what kinds of activities? _____

For women, are you pregnant? _____ Yes _____ No **Please let us know if you are planning to become pregnant during your treatment.**

Do you have any long-term diseases such as high blood pressure, diabetes, lupus, rheumatoid arthritis, kidney or liver disease? _____ Yes _____ No If yes, what do you have? _____

Are you HIV positive? _____ Yes _____ No

Do you have Hepatitis B or C? _____ Yes _____ No

Have you ever had cancer that's not skin cancer? _____ Yes _____ No If yes, what kind of cancer did you have? _____

Are you getting treatment for cancer right now? _____ Yes _____ No

Have you had an organ transplant? _____ Yes_____ No If yes, when and what type? _____

Have you had any of your joints replaced? _____ Yes _____ No If yes, when and what type?
_____

Have you had any heart valve problems? _____ Yes _____ No If yes, what kind of problems or treatment?
_____

Do you have a pacemaker (device that controls your heartbeat)? _____ Yes _____ No

Do you have a defibrillator (tool to give heart electric shock so it beats normally)? _____ Yes _____ No

Please tell us any other medical problems we should know about _____

Patient Signature_____ Date_____ Time_____

Approved by Atrium Health Corporate Health Literacy, March 2018

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