Richard A. Cirelli, M.D., P.C.

SunWest Dermatology and Skin Cancer Treatment Center

Patient Medical History Sheet

Patient Name: _____ Date of Birth: _____

Pharmacy Name _____

Street _____Zip Code _____ Telephone _____

Past Dermatologic/Skin History

Have you ever had skin cancer? □ Yes □ No

If YES, which kind: (circle all that apply) **Basal Cell Carcinoma/Squamous Cell Carcinoma/ Melanoma**

Do you have a family history of **MELANOMA**? □ Yes □ No If yes, which relative(s) _____

Do you have a family history of any other cancers such as breast, ovarian, pancreatic, prostate, lung, etc. in your family? □ Yes □ No

If yes, which relative(s), mother's or father's side and type of cancer _____

Other information we should know about your skin _____

Social History

Do you smoke? □ Yes □ No If YES, how many packs a day? _____ How much alcohol do you consume? _____

Past Major Medical History _____

_____

Ongoing Medical/Health Issues _____

_____

Alerts

Currently taking Blood thinners	□ Yes □ No	Pacemaker	□ Yes □ No
Artificial Joints within past 2 years	□ Yes □ No	Pre-medication prior to procedures	□ Yes □ No

Allergies Have you ever had an allergic reaction to any drug or medication? □ Yes □ No

If YES, please list the drug(s) and type of reaction(s):

_____

Are you allergic to latex? □ Yes □ No Are you allergic to adhesive? □ Yes □ No

Are you allergic to lidocaine / local anesthesia? □ Yes □ No

Medications ☐ NO current medications

Medication Name	Dosage	Reason	Medication Name	Dosage	Reason

By signing below, I acknowledge the information is true and correct to the best of my knowledge.

Patient Signature _____ **Date** _____

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