**VINCENT C. HUNG, M.D., F.A.C.S.**

PLEASE COMPLETE THE FOLLOWING MOHS MEDICAL HISTORY FORM

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_ Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**History of today's problem**

Skin area involved: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long has problem been present \_\_\_\_\_\_\_\_\_\_\_

Was there any previous treatment? ☐Yes ☐ No ☐ When? \_\_\_\_\_\_\_\_\_

Type of Treatment: ☐ burning ☐ radiation ☐excision ☐ liquid nitrogen ☐other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was a biopsy done? ☐Yes ☐No ☐biopsy done by referring doctor

**Name of doctors - Please mark none; if no specialist:**

**General: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cardiologist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Ophthalmologist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Radiologist/Oncologist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CHECK ALL THAT APPLY TO TODAY'S PROBLEM**

**Quality - A change of**: ☐ size ☐color ☐ elevation ☐ hardness ☐none ☐ other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Modifying Factors - a history of**: ☐none ☐UV light treatments ☐arsenic exp/treatments ☐chronic scar

☐x-ray treatments (not routine dental or chest x-rays) ☐immunosuppression

**Associated Symptoms**: ☐ bleeding ☐ pain ☐ tingling ☐ ulceration ☐ infection ☐ itching ☐ other \_\_\_\_\_\_\_\_

**Severity**: ☐ no symptoms ☐occasional symptoms ☐constant symptoms

**SYSTEMS REVIEW - CHECK ALL THAT APPLY REGARDING YOUR HEALTH AND ADD OTHER IMPORTANT PROBLEMS**

**Medications**: Allergic to any medications? ☐none ☐yes list them: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On any medication now? ☐none ☐yes list them: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On any blood thinners? ☐none ☐yes last taken: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Are you taking any Aspirin or Aspirin-like products (e.g. Aleve, Bufferin, and Motrin) ☐no ☐yes last taken: \_\_\_\_\_\_***

**Infections** **Hematologic/lymphatic** **Constitutional Symptom** **Eyes/Ears/Nose/Throat**

☐none ☐normal ☐none ☐normal

☐HIV/AIDS ☐anemia ☐weight loss/weight gain ☐glaucoma

☐hepatitis ☐bleeding problems ☐fever ☐hearing aid

☐tuberculosis (T.B.) ☐enlarged lymph nodes ☐other: \_\_\_\_\_\_\_\_\_\_\_\_\_ ☐plastic surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_

☐other: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Cardiovascular** **Respiratory** **Gastrointestinal** **Musculoskeletal**

☐normal ☐normal ☐normal ☐normal

☐angina ☐asthma ☐stomach ulcer ☐arthritis

☐artificial limb ☐emphysema ☐colitis ☐artificial joint

☐pacemaker ☐COPD ☐other GI problems: ☐other:

☐hypertension ☐other lung problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐mitral valve prolapse \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Neurological** **Psychiatric** **Endocrine** **Skin**

☐normal ☐normal ☐normal ☐abnormal scarring

☐stroke ☐depression ☐diabetes ☐poor healing

☐seizures ☐anxiety attacks ☐thyroid ☐other skin disorders

☐other: \_\_\_\_\_\_\_\_\_ ☐other: \_\_\_\_\_\_\_\_\_\_\_\_\_ ☐other: \_\_\_\_\_\_\_\_\_\_\_\_\_ ☐other \_\_\_\_\_\_\_\_\_**HISTORY**: **Previous skin cancer** - ☐none ☐see chart List: location/date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Major illness or hospitalizations**: ☐ none List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you take antibiotics prior to dental or other procedures**? ☐Yes ☐ no if yes, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History: skin cancer** ☐none ☐melanoma ☐basal cell ☐squamous cell list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you - Wear**: ☐ dentures ☐glasses ☐ contact lenses **Smoke**: ☐yes packs per day \_\_\_\_ ☐no ☐former smoker

**Drink alcohol**: ☐no ☐social/occasional drinking only ☐ other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Alcohol or drug problems/addictions**: ☐none ☐yes, describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_