METRO EAST
DERMATOLOGY & SKIN CANCER CENTER

Name: ____Date: ___________

Street Address: ______________________________City / State: _____________________

Zip Code: ____________________Date of Birth: _________________Gender: ___________

Phone Number (day): ____________________Phone Number (evening):_________________

Email Address:____

Emergency Contact:____

Preferred Pharmacy

Name: ____

Phone Number: ___________________________________

City and Zip Code: ________________________________

Past Medical History

Select any of the following medical conditions you currently have:

Anxiety
Arthritis
Asthma
Atrial Fibrillation
Bone Marrow Transplant
Benign Prostatic Hypertrophy
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
Hypertenstion
HIV/AIDS
Hypercholesterolemia
Hyperthryroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
NONE
Other___________________________

618-622-SKIN (7546)
618-622-7547
WWW.DERMSKINCANCERCENTER.COM

JAMIE L. MCGINNESS, MD | JACKIE MCGINNESS, FNP

1191 FORTUNE BLVD, SUITE 2
SHILOH, IL 62269

Past Surgical History

Have you had any surgeries on the following organs?

Appendix (Appendectomy)
Bladder (Cystectomy)
Breast: Breast Biopsy
Breast: Lumpectomy (Right, Left, Bilateral)
Breast: Mastectomy (Right, Left, Bilateral)
Colon (Colectomy): Colon Cancer Resection
Colon (Colectomy): Diverticulitis
Colon (Colectomy): Inflammatory Bowel Disease
Colon: Colostomy
Gallbladder (Cholecystectomy)
Heart: Coronary Artery Bypass Surgery
Heart: Heart Transplant
Heart: Mechanical Valve Replacement
Heart: PTCA
Joint Replacement: Hip (Right, Left, Bilateral)
Joint Replacement: Knee (Right, Left, Bilateral)
Kidney: Kidney Biopsy
Kidney: Kidney Stone Removal
Kidney: Kidney Transplant
Kidney: Nephrectomy
Liver: Hepatectomy
Liver: Liver Transplant
Liver: Shunt
Ovaries (Oophorectomy): Endometriosis
Ovaries (Oophorectomy): Ovarian Cancer
Ovaries (Oophorectomy): Ovarian Cyst
Ovaries: Tubal Ligation
Pancreas: Pancreatectomy
Prostate (Prostatectomy): Prostate Biopsy
Prostate (Prostatectomy: Prostate Cancer
Prostate (Prostatectomy): TURP
Rectum: APR
Rectum: Low Anterior Resection
Skin: Basal Cell Carcinoma
Skin: Melanoma
Skin: Skin Biopsy
Skin: Squamous Cell Carcinoma
Spleen (Splenectomy)
Testicles (Orchiectomy)
Uterus (Hysterectomy): Fibroids
Uterus (Hysterectomy): Uterine Cancer
Uterus (Hysterectomy): Cervical Cancer
NONE
Other______________________________
____
____

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Skin Disease History

Have you had any of the following?

Acne

Actinic Keratoses

Asthma

Basal Cell Skin Cancer

Blistering Sunburns

Dry Skin

Eczema

Flaking or Itchy Scalp

Have Fever / Allergies

Melanoma

Poison Ivy

Precancerous Moles

Psoriasis

Squamous Cell Skin Cancer

NONE

Other______________________________
____

Do you wear Sunscreen?

Yes No

If yes, what SPF?___________

Do you tan in a tanning salon?

Yes No

Do you have a family history of Melanoma?

Yes No

If yes, which relative?

Mother
Father
Sister
Brother
Daughter
Son
Uncle
Aunt
Nephew
Niece
Grandmother
Grandfather
Grandson
Granddaughter
Other____________________________

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Medications

List all current medications:

____
____
____
____
____
____
____
____
____
____
____
____
____
____

Allergies

List all allergies and reactions if known:

____
____
____
____
____

Social History

Smoking Status (please choose one):

Current every day smoker
Current someday smoker
Former smoker
Never smoker
Unknown if ever smoked

Start Smoking:

- mm/dd/yyyy ______________________

Quit Smoking:

- mm/dd/yyyy ______________________

Number of Packs Per Day: _________

Total Years Smoking: _____________

Alcohol Intake (please choose one):

None
1 or less per day
1-2 per day
3 or more per day

How many times in the past year have you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women or any adult older than 65?__________________

Driving Status:
Drives in the Daytime
Drives at Night

How often do you exercise?

Unspecified
Several times a day
Once a day
A few times a week
A few times a month
Never
Other

What is your caffeine use?

Unspecified
Several times a day
Once a day
A few times a week
A few times a month
Never
Other

Occupation and Workplace:
____
____

Place of Residence:
____
____

Family History

Please include only first-degree relatives:

____
____
____
____

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Review of Systems

Please check yes or no for the following:

Symptom	Yes	No
Problems with bleeding		
Problems with healing		
Problems with scarring (hypertrophic or keloid)		
Rash		
Immunosuppression		
Hay Fever		
Chest Pain		
Fever or Chills		
Night Sweats		
Unintentional Weight Loss		
Thyroid Problems		
Sore Throat		
Blurry Vision		
Abdominal pain		
Bloody stool		
Bloody urine		
Joint Aches		
Muscle weakness		
Neck Stiffness		
Headaches		
Seizures		
Cough		
Shortness of Breath		
Wheezing		
Anxiety		
Depression		

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Alerts

Please check yes or no for the following:

Symptom	Yes	No
Allergy to adhesive		
Allergy to lidocaine		
Allergy to topical antibiotic ointments		
Artificial heart valve		
Artificial joints within the past two years		
Blood thinners		
Defibrillator		
MRSA		
Pacemaker		
Premedication prior to procedures		
Rapid heartbeat with epinephrine		
Pregnancy or planning a pregnancy		