Girish S. Munavalli, MD, MHS · Payman Kosari, MD
Donna Lang, PA-C · Katie Daley, PA-C
General and Surgical Dermatology | Mohs Micrographic Skin Cancer Surgery
Leg Vein Center | Laser and Cosmetic Surgery

PATIENT MEDICAL HISTORY

Last Name _____ First Name _____ M.I. ___ D.O.B ___/___/_____ Age ____

Referring Physician or Source (radio, internet, etc) _____

Current (or previous) Dermatologist _____ Primary Care Physician _____

Pharmacy (name, city, and street; exact address not needed)_____

Occupation _____

MEDICATIONS (name and dose)	
1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

ALLERGIES (please list with reactions)	
1.	3.
2.	4.

SKIN CANCER/FAMILY HISTORY	YES	NO
Have you ever had basal cell or squamous cell carcinoma (BCC or SCC)?	☐	☐
Date/location:_____		
Have you ever had melanoma?	☐	☐
Date/location:_____		
Any family members with melanoma?	☐	☐
Date/location:_____		
Any family members with other skin cancer?	☐	☐
List:_____		

PREGNANCY AND NURSING		
Are you currently pregnant, nursing, or attempting conception?	☐YES	☐NO
If pregnant, how many weeks: _____		

SOCIAL HISTORY	YES	NO
Do you smoke?	☐	☐
- if yes, how many packs per day? _____		
Do you drink alcohol?	☐	☐
Do you use recreational drugs?	☐	☐
Do you exercise?	☐	☐

SURGICAL HISTORY	YES	NO
Do you take Coumadin, Plavix, Pradaxa, Xarelto, Eliquis, aspirin, or other blood thinners? If yes: _____	☐	☐
Do you have any artificial joints, heart valves, or other implanted material? If yes, please list: _____	☐	☐
Do you routinely take antibiotics before dental procedures?	☐	☐
Have you ever had a reaction to anesthesia?	☐	☐
Do you have liver or kidney disease?	☐	☐
Do you have a bleeding or clotting disorder?	☐	☐
Do you have a pacemaker or defibrillator?	☐	☐

PAST MEDICAL HISTORY	YES	NO
Have you received a flu vaccine this year?	☐	☐
Have you ever received a pneumococcal vaccine?	☐	☐
Diabetes	☐	☐
Heart disease	☐	☐
Have you ever tested positive for HIV/AIDS?	☐	☐
Have you ever tested positive for Hepatitis A/B/C?	☐	☐
Thyroid disease	☐	☐
Sexually transmitted diseases	☐	☐
Cancer (other than skin)	☐	☐
High blood pressure	☐	☐
Herpes simplex (cold sores)	☐	☐
Tuberculosis	☐	☐
Other conditions (please list): _____ _____ _____		

PAST SURGICAL HISTORY (please list with dates)	
1.	5.
2.	6.
3.	7.
4.	8.

Please turn over

REVIEW OF SYSTEMS

For each question, check yes or no

CONSTITUTIONAL	YES	NO
Fever	☐	☐
Weight loss	☐	☐
Chills	☐	☐

EYES		
Vision loss	☐	☐
Blurred vision	☐	☐

EARS, NOSE, MOUTH, THROAT		
Hearing loss	☐	☐
Congestion/runny nose	☐	☐
Sore throat	☐	☐

CARDIOVASCULAR		
Chest pain/pressure	☐	☐
Palpitations	☐	☐
Swelling in the legs	☐	☐

RESPIRATORY		
Shortness of breath	☐	☐
Cough	☐	☐

GASTROINTESTINAL		
Nausea/vomiting	☐	☐
Diarrhea	☐	☐
Decreased appetite	☐	☐
Abdominal pain	☐	☐

GENITOURINARY		
Pain/burning with urination	☐	☐

MUSCULOSKELETAL	YES	NO
Muscle pain	☐	☐
Back pain	☐	☐
Joint pain/stiffness	☐	☐

SKIN		
Psoriasis	☐	☐
Eczema	☐	☐

NEUROLOGIC		
Headache	☐	☐
Dizziness	☐	☐
Numbness/tingling	☐	☐

PSYCHIATRIC		
Depression	☐	☐
Anxiety	☐	☐
Sleep disturbance	☐	☐

ENDOCRINE		
Cold/heat intolerance	☐	☐
Night sweats	☐	☐
Excessive urination	☐	☐

HEMATOLOGIC/LYMPHATIC		
Easy bruising/bleeding	☐	☐
Anemia	☐	☐

ALLERGIC/IMMUNE		
Asthma	☐	☐
Hives	☐	☐
Hay fever	☐	☐

VEIN SYMPTOMS
(if you have varicose veins, or are here for a vein consultation)

	YES	NO		YES	NO
Pain/Aching	☐	☐	Swelling	☐	☐
Throbbing	☐	☐	Leg cramps	☐	☐
Tired/heavy legs	☐	☐	Restlessness	☐	☐
Itching	☐	☐	Ulcers	☐	☐

LIFESTYLE	YES	NO
Does leg pain interfere with your daily life?	☐	☐
Is your discomfort getting worse?	☐	☐
Are symptoms worse with prolonged standing?	☐	☐
Do you take medication for leg pain?	☐	☐

HISTORY

Family history of Varicose Veins?	☐ father	☐ mother		
Ever worn support hose from a doctor?		☐YES	☐NO	
-if so, did they provide relief?		☐YES	☐NO	
Have you ever had a miscarriage?		☐YES	☐NO	

Previous vein evaluation/treatment(s): (***check applicable***)			
☐ stripping	☐ laser	☐ surgery	☐ injections
-if so, where & when?:			
History of: (***check applicable***)	☐ phlebitis	☐ blood clots	

To the best of my knowledge, the above information is accurate and complete.

Patient Signature: _____ DATE: _____

Reviewed by (provider signature): _____ DATE: _____ MA Initials: ____

Please turn over