Girish S. Munavalli, MD, MHS · Payman Kosari, MD · Hayley Leight-Dunn, MD · Amit Om, MD
Katie Daley, PA-C · Aaron Blackmer, PA-C · Rachel Yang, NP-C
Amber Blair, MMS, PA-C · Leila Esmaeili, PA-C
General and Surgical Dermatology | Mohs Micrographic Skin Cancer Surgery
Leg Vein Center | Laser and Cosmetic Surgery | Clinical Trials

PATIENT MEDICAL HISTORY

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

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

Current (or previous) Dermatologist _____ Primary Care Physician _____

Pharmacy (name, city, & street) _____ Occupation _____

(patients 65+) Do you have a health proxy/power of attorney? Name/Phone #_____

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? _____		

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)	

Please turn over

Do you drink alcohol?	☐	☐
Do you use recreational drugs?	☐	☐
Do you exercise?	☐	☐

1.	5.
2.	6.
3.	7.
4.	8.

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.

Please turn over

Patient Signature: _____ DATE: _____

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

Please turn over