Massachusetts General Hospital
Founding Member, Mass General Brigham

High Risk Skin Cancer Clinic New Patient History

Print your name:
Print date of birth:
Medical Record Number (*if known*):

REFERRING PROVIDER:

Name: _____
Address: _____
City / State: _____ Specialty: _____

TRANSPLANT PHYSICIAN OR ONCOLOGIST:

Name: _____

TRANSPLANT AND LEUKEMIA / LYMPHOMA HISTORY:

Organ transplant	❒ NO	❒ YES	Organ:	Date of transplant:
Leukemia or Lymphoma	❒ NO	❒ YES	Type:	Date of onset:

SKIN CANCER HISTORY:

Do you use sunscreen on the majority of days in the week, regardless of the weather outside?	❒ NO	❒ YES	Comments:
Have you ever had a blistering sunburn?	❒ NO	❒ YES	Location(s):
Current or past history of warts?	❒ NO	❒ YES	Location(s):
Current or past history of pre-cancerous lesions (actinic keratoses)?	❒ NO	❒ YES	Location(s):

History of skin cancers? ❒ NO ❒ YES

	❒ BCC	❒ SCC	❒ Melanoma
Number of Cancers:	#	#	#
Location(s):			

History of skin cancer(s) requiring radiation or that have spread to lymph nodes or other organs?	❒ NO	❒ YES	Location(s):
Any diagnosed skin cancers not yet treated?	❒ NO	❒ YES	Location(s):

OTHER PAST MEDICAL HISTORY:

High cholesterol	❒ NO	❒ YES	Details:
Diabetes	❒ NO	❒ YES	Details:
Liver or kidney disease	❒ NO	❒ YES	Details:
Hepatitis or HIV	❒ NO	❒ YES	Details:
Pacemaker or implantable cardioverter	❒ NO	❒ YES	Details:

Other medical issues:_____

Please turn over and complete side 2

IMMUNOSUPPRESSIVE MEDICATIONS (WITH DOSAGES):

(1) _____ **(2)** _____ **(3)** _____

OTHER MEDICATIONS: Do you take any prescription or over- the-counter medications regularly? Please list:

(1) _____ **(2)** _____ **(3)** _____

(4) _____ **(5)** _____ **(6)** _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? ❒ NO ❒ YES If yes, please list: _____

FAMILY HISTORY:

Do you have a family history of skin cancer?	❒ NO ❒ YES	Type of skin cancer:	Relationship to you:

SOCIAL HISTORY:

Are you currently employed?	❒ NO ❒ YES	Type of work?
If not currently employed, what type of work did you do before your illness?		

REVIEW OF SYSTEMS: Do you have current problems with any of the following?

		Please describe:
Unintentional weight loss	❒ NO ❒ YES	
Fevers, chills, or night sweats	❒ NO ❒ YES	
Worsening headaches or dizziness	❒ NO ❒ YES	
Visual changes	❒ NO ❒ YES	
Nausea, vomiting, or abdominal pain	❒ NO ❒ YES	
Shortness of breath	❒ NO ❒ YES	
Skin pain or numbness	❒ NO ❒ YES	
Swollen glands	❒ NO ❒ YES	
Females: Are you pregnant, planning pregnancy, or currently nursing?	❒ NO ❒ YES	

❒ I authorize Dermatology to leave test results and other messages on the following telephone #:_____

❒ I authorize the Dermatology Service to release medical information to the referring physicians.

Patient's Signature **Today's Date** **Physician's signature** **Today's Date**