Scott L. Darling, D.O., P.C.
Skin, Vein & Skin Surgery Center

New Patient Medical History Form

Patient: ____ Date of Birth: ____________ Date of Visit: ___________
Referred by: ☐ Self ☐ Relative/Friend ☐ Dr. ____
Reason for today's visit: ____
Body site(s) involved: ____
When did it begin? ____
What symptoms are associated? ☐ None ☐ Bleeding ☐ Scabbing ☐ Crusting ☐ Never seems to heal
☐ Tenderness ☐ Irritation ☐ Other: ______________________________
Was this ever treated before? ☐ No ☐ Yes Method: ☐ Surgery ☐ Freezing/Burning ☐ Medication: ______________

Please list your current medications: ____

____

Do you take aspirin, Plavix, or Coumadin/Warfarin? Yes ☐ No ☐
Do you have any allergies to medications? Yes ☐ No ☐ If yes, list medications and reaction type:
____

Please check appropriate box (es) of any of your past or current medical conditions:

General
☐ Unexplained fever
☐ Unexplained weight change
☐ Night sweats
☐ Anorexia
☐ Other:

Skin
☐ Abnormal Scarring
☐ Poor wound healing
☐ Sensitive skin
☐ Cold sores/fever blisters
☐ Other:

Infectious Disease
☐ HIV/AIDS
☐ Tuberculosis
☐ Hepatitis B
☐ Hepatitis C
☐ Other:

Cardiac
☐ Pacemaker
☐ Defibrillator
☐ Bypass surgery
☐ High Blood Pressure
☐ Heart Murmur
☐ Chest Pain
☐ Other:

Pulmonary
☐ Shortness of breath
☐ Cough
☐ Asthma
☐ Other:

Endocrine
☐ Diabetes
☐ Thyroid Disease
☐ Other:

Gastrointestinal
☐ Nausea/vomiting/diarrhea
☐ Colon polyp or cancer
☐ Irritable bowel disease
☐ Other:

Renal /Urology
☐ Dialysis
☐ Prostate disease
☐ Other:

Orthopedic
☐ Artificial joint
☐ Prosthesis
☐ Other:

Hematology
☐ Bleeding disorder
☐ Easy bruising
☐ Blood clots
☐ Other:

Immune System
☐ Organ Transplant
Type: ____________
☐ Previous or current cancer
Type: ____________
☐ Current or past chemotherapy
☐ Other:

Neurology
☐ Stroke
☐ Dizziness
☐ Weakness of arms/legs
☐ Decreased sensation
☐ Other:

Ob/Gyn
☐ Currently pregnant
☐ Trying to conceive
☐ Hysterectomy
☐ Frequent yeast infections
☐ Other:

Please list any other medical conditions: ____
Please List any previous surgeries with dates: ____

Skin Cancer and Surgery Related Questions:
Have you ever had a skin cancer? Yes ☐ No ☐ List: ______________________________
Have you ever had a sunburn? Yes ☐ No ☐
Do you have a family history of skin cancer? Yes ☐ No ☐ Was it melanoma? Yes ☐ No ☐ Uncertain ☐
Have you previously used a tanning booth? Yes ☐ No ☐
Do you currently or periodically use a tanning booth? Yes ☐ No ☐
Do you take protective measures? ☐ Yes: ☐ Sunscreen ☐ Sunglasses ☐ Hat ☐ Avoiding midday sun ☐ None of these
How often do you monitor your skin for sun damage/cancer? ☐ Not regularly ☐ Monthly self check ☐ Routine checkup with Dr

Occupation: ______________________________ Hobbies: ______________________________
Do you Smoke? ☐ Yes ☐ No If yes, how many packs per day? ____________
Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per week? ____________

This form was completed by: ☐ Patient
☐ Family or friend
☐ Medical Staff________ (Initials)

Patient accompanied by: ☐ Spouse
☐ Other family member:
☐ Parent ☐ Friend

I hereby acknowledge that the completed information is accurate:
Signature of Patient or representative: ______________________________ Date: ____________

Reviewed by: ______________________________ Date: ____________