# HUNTERDON DERMATOLOGY, LLC
## Christopher T. Cassetty, M.D.

**Name**_____ **Date**_____ **Age**_____

**Reason for today's visit:** Check up Other: _____

**Past Medical History:** (please circle all that apply) None

| | | |
|---|---|---|
| Anxiety | Depression | Hypothyroidism (underactive) |
| Arthritis | Diabetes | Leukemia |
| Asthma | End Stage Renal Disease | Lung Cancer |
| Atrial fibrillation | GERD | Lymphoma |
| BPH | Hearing Loss | Prostate Cancer |
| Bone Marrow Transplant | Hepatitis | Radiation Treatment |
| Breast Cancer | High Blood Pressure | Seizures |
| Colon Cancer | HIV/AIDS | Stroke |
| COPD | High Cholesterol | |
| Coronary Artery Disease | Hyperthyroidism (overactive) | |

Other Important Medical History _____

**Past Surgical History:** (please circle all that apply) None

| | |
|---|---|
| Appendix Removed | Kidney Biopsy |
| Bladder Removed | Kidney Removed (Right, Left) |
| Breast: Mastectomy (Right, Left, Bilateral) | Kidney Stone Removal |
| Breast: Lumpectomy (Right, Left, Bilateral) | Kidney Transplant |
| Breast Biopsy (Right, Left, Bilateral) | Ovaries Removed: Endometriosis |
| Breast Reduction | Ovaries Removed: Cyst |
| Breast Implants | Ovaries Removed: Ovarian Cancer |
| Colectomy: Colon Cancer Resection | Prostate Removed: Prostate Cancer |
| Colectomy: Diverticulitis | Prostate Biopsy |
| Colectomy: IBD | Prostate: TURP |
| Gallbladder Removed | Skin Biopsy |
| Heart: Coronary Artery Bypass (CABG) | Skin: Basal Cell Carcinoma Surgery |
| Heart: PTCA (angioplasty) | Skin: Squamous Cell Carcinoma Surgery |
| Heart: Mechanical Valve Replacement | Skin: Melanoma Surgery |
| Heart: Biological Valve Replacement | Spleen Removed |
| Heart Transplant | Testicles Removed (Right, Left, Bilateral) |
| Joint Replacement, Knee (Right, Left, Bilateral) | Tonsillectomy / Adenoidectomy |
| Joint Replacement, Hip (Right, Left, Bilateral) | Uterus/ Hysterectomy: Fibroids |
| Joint Replacement within last 2 years | Uterus/ Hysterectomy: Uterine Cancer |

Other Important Surgical History _____

**Skin Disease History:** (please circle all that apply) None

| | | |
|---|---|---|
| Acne | Dry Skin | Poison Ivy |
| Actinic Keratosis (pre-cancer) | Eczema | Precancerous Moles |
| Asthma | Flaking or Itchy Scalp | Psoriasis |
| Basal Cell Skin Cancer | Hay Fever/Allergies | Squamous Cell Skin Cancer |
| Blistering Sunburns | Melanoma | |

Other _____

BCC or SCC: Year _____ Location _____ Treatment _____

Melanoma: Year _____ Depth _____ Location _____ Treatment _____

Do you wear Sunscreen? Yes No What SPF? ____

Have you tanned in a tanning salon? Yes No If Yes, at what age was the first time? _____

**Family History:**

Do you have a family history of Melanoma? Yes No If yes, which relative(s)? _____

Please list primary **Local Pharmacy** (name, city, zip and phone) _____

_____

Please list **Mail Order Pharmacy** (name) _____

**Medications:** (Please enter all current medications)

1._____ 6._____

2._____ 7._____

3._____ 8._____

4._____ 9._____

5._____ 10._____

**Allergies to Medications:** (Please enter all medication allergies and reactions)

_____

_____

**Social History:** (Please circle all that apply)

**Smoking Use:**

Currently Smokes – daily
Currently Smokes - not daily
Has never smoked
Has smoked in the past

**Alcohol Use**:

None
Less than 1 drink per day
1-2 drinks per day
3 or more drinks per day

**IV Drug Use:**

Other_____

**Review of Systems:** (Please circle all that apply regarding your overall health and add any other important information)

Allergy to adhesive
Allergy to lidocaine
Allergy to topical antibiotic ointments
Artificial Heart Valve
Artificial Joints in the last two years
Blood Thinners
Changing mole
Defibrillator
GI upset with antibiotics
Hepatitis
HIV/AIDS
Immunosuppression
Pacemaker
Pregnancy or planning a pregnancy
Premedication prior to procedures
Problems with bleeding
Problems with healing
Problems with scarring (hypertrophic or keloid)
Rapid heartbeat with epinephrine
Rash
Yeast infections with antibiotics

Abdominal Pain
Anxiety
Bloody stool
Bloody urine
Blurry vision
Chest pain
Cough
Depression
Fever or chills
Headaches
Hay fever
Joint aches
Muscle weakness
Neck stiffness
Night Sweats
Seizures
Shortness of Breath
Sore throat
Thyroid problems
Weight loss – unintentional
Wheezing

May we leave a message at home if you do not answer the phone? Yes No

Emergency Contact Name_____ Relation _____ Phone _____