California Skin Surgery Center

Gregory M. Bricca, M.D., Inc.

Last Name _____ **First Name** _____ **MI** _____ **Date of Birth** ____/____/____
MM / DD / YYYY

Medical History

Past Medical History/Review of Systems: Do you currently have or have you ever had any of the following?
(Please give details. Fill out completely. If you have no problems in a particular system, please check **Normal**.)

Skin
- ☐ **Normal**
- ☐ Basal Cell Carcinoma
- ☐ Squamous Cell Carcinoma
- ☐ Melanoma
- ☐ Thick Scars/Keloids
- ☐ Atypical Moles
- ☐ Other _____

Cardiovascular
- ☐ **Normal**
- ☐ Chest pain
- ☐ Heart Attack
- ☐ Pacemaker
- ☐ Heart Valve Replacement
- ☐ High blood pressure
- ☐ Other _____

Musculoskeletal
- ☐ **Normal**
- ☐ Muscle Weakness
- ☐ Fibromyalgia
- ☐ Joint Replacement

Joint / Date:_____

Joint / Date:_____

Neurological
- ☐ **Normal**
- ☐ Seizure
- ☐ Stroke
- ☐ Nerve pain
- ☐ Numbness/Tingling
- ☐ Other _____

Respiratory
- ☐ **Normal**
- ☐ Asthma
- ☐ Emphysema
- ☐ Cough
- ☐ Other _____

Gastrointestinal
- ☐ **Normal**
- ☐ Stomach Ulcer
- ☐ Colitis
- ☐ Liver Problems
- ☐ Other _____

Hematologic/Lymphatic
- ☐ **Normal**
- ☐ Anemia
- ☐ Bleeding Problems
- ☐ Cancer/Enlarged Lymph Nodes
- ☐ Other _____

Eye/Ear/Nose/Throat
- ☐ **Normal**
- ☐ Glaucoma
- ☐ Hearing Aid - Right / Left
- ☐ Plastic Surgery _____
- ☐ Other _____

Psychiatric
- ☐ **Normal**
- ☐ Depression
- ☐ Anxiety
- ☐ Dementia
- ☐ Other _____

Endocrine
- ☐ **Normal**
- ☐ Diabetes
- ☐ Thyroid
- ☐ Oral Steroid Use
- ☐ Other _____

Infections
- ☐ **Normal**
- ☐ Hepatitis (circle) A, B or C
- ☐ HIV / AIDS
- ☐ Tuberculosis / TB
- ☐ Cold Sores / Other _____

Genitourinary
- ☐ **Normal**
- ☐ Dialysis
- ☐ Kidney Problems
- ☐ Venereal Disease
- ☐ Other _____

Allergic/Immunologic
- ☐ **Normal**
- ☐ Lupus
- ☐ Organ Transplantation
- ☐ Chemotherapy
- ☐ Other _____

Constitutional
- ☐ **Normal**
- ☐ Current Weight _____
- ☐ Weight Loss
- ☐ Other _____

Have you ever had complications with local anesthesia? Y / N
If yes, please explain:_____

Are you currently pregnant, planning to become pregnant, or nursing? Y / N

Are you allergic to latex or rubber? Y / N
If yes, please explain:_____

Have you fallen in the last year? Y / N
☐Once ☐ 2 or more times
☐w/ injury ☐ w/o injury

Current medications: ☐ **None** (Please list all prescription and over- the-counter medications **with each dosage and frequency that you take them)**

_____

_____

_____

Medication Allergies: ☐**None** (Please list all **medication** allergies and **describe each reaction** to them) _____

_____

_____

Past Surgeries (skin cancer included) ☐ **None** _____

_____

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Social History / Demographic Questionnaire

(continued from front…)

Occupation:_____

Tobacco Use

☐ Never a tobacco smoker ☐ Currently tobacco smoker Cigarettes per day:_____ ☐ Former tobacco smoker How long has it been since you last smoked? _____

Alcohol use

Did you have a drink containing alcohol in the past year? **Y / N** (if no, skip to the next section)

How often did you have a drink containing alcohol in the past year?

☐ Less than once a month ☐ 2 – 4 times a month ☐ 2 – 3 times per week ☐ 4 or more times per week

How many drinks did you have on a typical day when you were drinking in the past year?

☐ 1 – 2 ☐ 3 – 4 ☐ 5 – 6 ☐ 7 – 9 ☐10 or more

How often did you have 6 or more drinks on one occasion in the past year?

☐ Never ☐ Less than once a month ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Family history

☐ No family history of skin cancer of any kind

☐ Family history of:

- Melanoma, relation:_____
- Non-melanoma skin cancer, relation:_____
- Other skin problems, relation_____
- Anesthetic complications, relation:_____

Do you use sunscreen? Y / N

Advanced Directive

☐ I have an Advance Directive, but I did not bring a copy with me to submit today. ☐ I am aware of California Skin Surgery Center's policy on Advance Directives, and I am submitting a copy of mine for my record should I require hospital transfer. ☐ I do not have an Advance Directive.

Please add my e-mail to my file:_____

We value your privacy. Your personal information will be kept confidential and will never be sold to third parties. It will only be used for communications you request related to the services provided by Gregory M. Bricca, MD and the California Skin Surgery Center

Optional questions:

Decline to state ☐ Race:_____ **Ethnicity**:_____ **Language**:_____

Patient Signature _____ **Date** ____/____/____