ADVANCED LASER & SKIN CANCER CENTER, LLC

870 Palisade Avenue, Suite 302, Teaneck, NJ 07666 Tel.: (201)836-9696 Fax: (201-836-4716)
website: www.mohsnj.net

Patient Name:____

Why are you here today?____

Referring Physician: ____

Referring Physician Phone # (______)____

Primary Care Doctor: ____

Primary Care Phone # (_____)____

When was your last visit to your Primary care doctor? _____________________________________

Pharmacy Name: ______________________________**Phone:** ________________________________

Street:____ **Zip code:** ___________________

Date of Birth: ___________________________ **Gender:** Female or Male

Female Date of Last Menstrual Cycle ___________________________

Past Medical History: (please CIRCLE all that apply):

Anxiety	End Stage Renal Disease	Leukemia
Arthritis	GERD	Lung Cancer
Asthma	Hearing Loss	Lymphoma
Atrial fibrillation	Hepatitis	Prostate Cancer
Bone Marrow Transplant	High Blood Pressure	Radiation Treatment
BPH	HIV/AIDS	Seizures
Breast Cancer	High Cholesterol	Stroke
Colon Cancer	Thyroid Problems (Hyper or Hypo)	Pacemaker
Chronic Obstructive	Depression	NONE

Do you have any of the following? (Please CIRCLE all that apply):

HEART FAILURE DIABETES COPD (Pulmonary Disease) CAD (Coronary Artery Disease)

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Past Surgical History: (please list all that apply):

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Skin Disease History: (please CIRCLE all that apply):

Acne Dry	Dry Skin	Poison Ivy
Actinic Keratosis	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	NONE

Medications: (Please enter all current medications):

Rx:______________DOSE_____FREQUENCY______ Rx:______________DOSE_____FREQUENCY______
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Allergies: (Please enter all allergies, including medication allergies):

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All Patients Have you received the flu vaccine this year? ☐ Yes ☐ No
(Reason):_____________________

Do you have a history of Melanoma? ☐ Yes ☐ No

Are you on a biologic (ex: Stelara) for psoriasis? ☐ Yes ☐ No

List current height and weight: Height: ____ ft _____ in **Weight:** ____________ lbs

Patients 12 and older Tobacco Use: ☐ Smoker ☐ Non-smoker

Patients 65 and older Do you have an Advance Care Plan/Directive?
☐ Yes (please name your Surrogate Decision Maker: _____________________________
☐ Decline to answer Have you EVER received the pneumonia vaccine? ☐ Yes ☐ No