

Masada Private Hospital

26 Balaclava Road East St Kilda Vic 3183
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DERMATOLOGY MEDICAL HISTORY

Unit Record Number:

Admission Number:

Family Name: _____

Given Names: _____

Date of Birth: Age: Sex:

OR USE LABEL

1. PAST MEDICAL HISTORY	YES	NO
Have you ever suffered from any of the following:		
Diabetes Type 1 or Type 2 (Please circle)		
Bleeding Disorder - including post-operative bleeding		
Blood clot in lungs / leg		
High blood pressure		
Asthma		
Stroke		
Heart attack / disease		
Heart valve		
Cardiac pacemaker		
Epilepsy		
Joint Replacement & Vascular grafts - if YES , then date		
AIDS / Hepatitis		
Other illnesses		

2. ALLERGIES	YES	NO
Are you allergic to any medications, drugs, latex, sticky tape, anaesthetic, ointments or creams?		
If so please state:		

3. CURRENT MEDICATIONS / DRUGS / HERBAL REMEDIES	YES	NO	DRUG NAME
Aspirin			
Warfarin / Dindevan			
Digoxin			
Blood Pressure Drugs			
Cortisone / Prednisolone			
Arthritis Drugs			
Antibiotics			
Other Medications			

Please List:

4. SMOKING	YES	NO
Do you smoke?		
If so, how many per day?		

5. PREVIOUS SKIN CANCER SURGERY	YES	NO
Have you previously had surgery for treatment of skin cancer?		

If YES, please state what type of skin cancer including Melanoma, and date of surgery: