



5783 Wooster Pike, Medina, Ohio 44256
phone 330.725.0569 fax 330.662.0258 www.TrilliumCreekOhio.com

Dermatology & Surgery Center | Mohs Skin Cancer Center | Ohio Holistic Medicine | The Boutique at Trillium Creek

PATIENT INFORMATION

Patient Name: _____ **Date:** _____

Date of Birth: _____ **Age:** _____

_____ New Patient _____ Established Patient

Reason for today's visit: _____

Physician referred by: _____

If available today, would you like to be treated holistically? ___Yes ___No

Are you allergic to any medications? If so, please list: _____

List all prescription medications you are currently taking: _____

Do you taking aspirin daily? ___Yes ___No
Are you on any blood thinners? ___Yes ___No
Are you pregnant? ___Yes ___No
Are you trying to get pregnant? ___Yes ___No

Do you have now, or have you ever had any of the following conditions?

(X) all that apply

Respiratory

_____ Asthma
_____ Tuberculosis
_____ Wheezing

Endocrine

_____ Diabetes
_____ Hyperthyroid
_____ Hypothyroid
_____ Kidney Problems
_____ High Cholesterol



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Cardiovascular

- High Blood Pressure
- Chest Pain
- Mitral Valve Prolapse
- Irregular Heartbeat
- Phlebitis
- Pacemaker
- Shortness of Breath

Muscular

- Arthritis
- Limited Motion

Patient's Past Medical History

Have you ever had skin cancer? Yes No

If yes, please list the type of skin cancer, the location and how and when it was treated: _____

Do you have any history of HIV/AIDS? Yes No

Any history of atypical moles? Yes No

If yes, please list the location of these moles: _____

Any history of melanomas? Yes No

If yes, please list the location and how and when it was treated: _____

Any history of cancer? Yes No

If yes, please list the type and treatment: _____

Do you have a history of eczema? Yes No

Do you develop keloids? Yes No

Do you have a history of psoriasis? Yes No

Please list any other diseases or conditions: _____



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Please list any surgeries in the last 5 years: _____

Please list any hospitalizations in the last 5 years: _____

Family Medical History

Any family history of skin cancer? ___Yes ___No

If yes, who and the type of skin cancer: _____

Any family history of cancer? ___Yes ___No

If yes, who and the type of cancer: _____

Any family history of melanoma? ___Yes ___No

If yes, who? _____

Any family history of eczema? ___Yes ___No

Any family history of psoriasis? ___Yes ___No

Patient's Social History

Do you smoke? ___Yes ___No If yes, how many per day? _____

Do you drink alcohol? ___Yes ___No If yes, how many drinks per week? _____

What is your occupation? _____

What would you consider your sun exposure to be? (X) one choice below

_____ Minimal

_____ Moderate

_____ Excessive

Patient Signature: _____ **Date:** _____

Attending Provider Signature: _____