VIRGINIAdermatology
& skin cancer center
Brian L. Johnson, M.D.

DATE: _____/_______/______

Name:__________________________________ DOB:________________________ Age:_______

Gender: M F Referring Physician:____

History & Physical

Where is the lesion?_______________How long have you known about the lesion?__________

Allergic to any medications?______________________Reaction to medication?_____________

What color was it? ___________________ How did it change?_________________________
(red, brown, flesh colored) (increase in size, ooze, bleed, crust)

When did you first see a doctor about the area?______ What did your doctor do?___________

List your current medications including over the counter medications, vitamins and herbal supplements:

____

____

Have you ever had any radiation treatments for acne or any other medical condition? If so, when?

____

List previous skin cancer history. Include type and treatment: _____________________________

____

Do you have any of the following medical problems? Please X

____Hypertension	____Bleeding Tendencies	____Arthritis
____Stomach Problems	____Kidney	____Diabetes
____Lung Problems	____High Cholesterol	____Pacemaker
____Thyroid	____Thick scar after surgery (keloid)	____Heart Valve
____Artificial Joint	____Infectious Disease	____Blood Disorder

Other:____

Do you smoke? Y N How much:____

Do you drink? Y N How much:____

Do you take antibiotics prior to surgery or dental work to protect artificial joints or heart valve from infection?
Y N

For nurse use only:

We advise you to:

Continue all medication as directed by your doctors including blood thinners ____ Initials

Stop all alcoholic beverages 3 days prior & after surgery ____Initials

Location of lesion: ______________________Histopath Dx:____________________

Size: ___________________ Prev. Tx.:______________________________

Laboratory: ______________________Path#:_______________________________

Pre-operative Meds: ____

Special recommendations:____

Consult w/plastic date: ______________MD:__________________ Phone: _____________

Mohs surgery date/time:_______________________ Reconstruction date:________________