John Q. Binhlam, M.D., P.C.
Advanced Skin & Laser Center (ASLC)

Patient Name_____**DOB**_____

What is the reason for being seen today?_____

Do you have now or have you ever had any of the following past medical history?

	Y	N		Y	N		Y	N		Y	N
Anxiety	□	□	Colon Cancer	□	□	Hearing Loss	□	□	Leukemia	□	□
Arthritis/Joint Pain	□	□	COPD	□	□	Hepatitis B or C	□	□	Lung Cancer	□	□
Asthma	□	□	Coronary Artery Disease	□	□	High Blood Pressure	□	□	Lymphoma	□	□
Atrial Fibrillation	□	□	Depression	□	□	HIV/AIDS	□	□	Prostate Cancer	□	□
BPH (Enlarged Prostate)	□	□	Diabetes	□	□	High Cholesterol	□	□	Radiation Treatment	□	□
Bone Marrow Transplant	□	□	Kidney Disease	□	□	Hyperthyroidism	□	□	Seizures/Epilepsy	□	□
Breast Cancer	□	□	Acid Reflux-GERD	□	□	Hypothyroidism	□	□	Stroke	□	□
Other:											

Have you had surgeries on the following organs?

	Y	N		Y	N		Y	N		Y	N
Appendectomy	□	□	Heart Bypass Surg	□	□	Endometriosis	□	□	Melanoma	□	□
Bladder Surgery	□	□	Heart Transplant	□	□	Ovarian Cancer	□	□	Skin Biopsy	□	□
Breast Biopsy	□	□	Heart PTCA	□	□	Ovarian Cyst	□	□	Squamous Cell Cancer	□	□
Breast Lumpectomy	□	□	Joint Replacement	□	□	Tubal Ligation	□	□	Splenectomy	□	□
Breast Mastectomy	□	□	Area_____			Pancreatectomy	□	□	Orchiectomy	□	□
Colon Cancer Resection	□	□	Kidney Biopsy	□	□	Prostate Biopsy	□	□	Fibroids	□	□
Diverticulitis	□	□	Kidney Stone	□	□	Prostate Cancer	□	□	Uterine Cancer	□	□
Bowel Disease	□	□	Kidney Transplant	□	□	Prostatectomy	□	□	Cervical Cancer	□	□
Colostomy	□	□	Liver Disease	□	□	Rectal Disease	□	□			
Gallbladder Surgery	□	□	Liver Transplant	□	□	Rectal Resection	□	□			
Heart Valve Replacement	□	□	Liver Shunt	□	□	Basal Cell Carcinoma	□	□			
Other:											

Have you had any of the following Skin Conditions?

	Y	N		Y	N		Y	N		Y	N
Acne	□	□	Dry Skin	□	□	Melanoma (MM)	□	□	Squamous Cell Cancer	□	□
Pre Cancerous Lesions	□	□	Eczema	□	□	Poison Ivy	□	□	Rosacea	□	□
Basal Cell Carcinoma	□	□	Flaking/Itchy Scalp	□	□	Precancerous Moles	□	□	Fever Blisters	□	□
Blistering Sunburns	□	□	Skin Rashes	□	□	Psoriasis	□	□	Keloids	□	□
Do you wear Sunscreen?	□	□	Tanning bed use?	□	□	Problems healing	□	□	Family hx of Melanoma	□	□
Other:											

Social History

What is your occupation?

	Y	N	
Do you drink alcohol?	□	□	if yes, how often_____
Do you smoke?	□	□	if yes, how many per day_____
Do you chew tobacco?	□	□	if yes, how often_____
Do you use illegal drugs?	□	□	if yes, what type and how often_____

FEMALES ONLY	Y	N		Y	N		Y	N		Y	N
Are you Pregnant?	□	□	Trying to get Pregnant?	□	□	Breastfeeding ?	□	□	Using Contraception?	□	□

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Patient Name_____ **DOB**_____

Please list all Current Medications including Over the Counter and Supplements

	Medication Name (if none, please write none)	Dosage	Number times per day	Notes
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Allergies (if none, please write none)		
	Medications and/or Other Allergens	What type of Reaction?
1		
2		
3		
4		
5		
6		
7		
8		

Are you allergic to Lidocaine? ____Yes ____No Are you allergic to Latex? ____Yes ____No	
Are you allergic to Adhesive tape? ___Yes ____No	

Patient or Legal Guradian Signature_____Date_____/_____/_____

Relationship to Patient:_____

Nurse/Assistant Signature:_____Date:_____/_____/_____

Physician/MidLevel Provider Signature:_____Date:_____/_____/_____