

Name: _____ Date of Birth: _____ MRN# _____ PLG# _____

Please try to answer all the following questions about your medical history and demographics (information on young children should be completed by parents). Please make sure you fill out all of the 5 pages. Use the reverse side of a page if you need more room. Our nursing staff can assist you when you are called to an exam room if you are unable to answer any questions.

Have you <u>ever</u> been told by a doctor that you had any of the following:	Where was it on your body?	Date(s) of surgery?	Name of doctor(s) who treated you?	Hospital, City, and State where treated?
Melanoma skin cancer <input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____	_____	_____
Removal of a mole <input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____	_____	_____
Basal cell skin cancer <input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____	_____	_____
Squamous cell skin cancer <input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____	_____	_____
Other non-melanoma skin cancer <input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____	_____	_____
Cancer (other than skin cancers) <input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____	_____	_____

List year and type of all other past/present major illnesses:	List year and reason for all other past major surgeries:

List all prescription and over-the-counter medications: (include birth control pills, vitamins, aspirin, Advil, Motrin and natural herbs).	Are you allergic to any medications? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please list medications and type of reaction:

Do you check your skin regularly for changes? <input type="checkbox"/> No <input type="checkbox"/> Yes
Have any of your moles changed or have new moles or bumps appeared on your skin? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please describe:

Have you been experiencing any of the following?	
Unexplained weight loss <input type="checkbox"/> No <input type="checkbox"/> Yes	Bowel or bladder problems <input type="checkbox"/> No <input type="checkbox"/> Yes
Debilitating fatigue <input type="checkbox"/> No <input type="checkbox"/> Yes	Chest pain, cough <input type="checkbox"/> No <input type="checkbox"/> Yes
Swelling or tenderness in neck, armpits, groin <input type="checkbox"/> No <input type="checkbox"/> Yes	Stomach pain, nausea, vomiting <input type="checkbox"/> No <input type="checkbox"/> Yes
Severe or persistent headaches <input type="checkbox"/> No <input type="checkbox"/> Yes	Joint or bone pain <input type="checkbox"/> No <input type="checkbox"/> Yes
Dizziness, numbness, unusual sensations <input type="checkbox"/> No <input type="checkbox"/> Yes	Other problems with pain <input type="checkbox"/> No <input type="checkbox"/> Yes _____
Difficulty swallowing <input type="checkbox"/> No <input type="checkbox"/> Yes	Depression or anxiety <input type="checkbox"/> No <input type="checkbox"/> Yes
Special dietary problems <input type="checkbox"/> No <input type="checkbox"/> Yes	Limitations in physical activity <input type="checkbox"/> No <input type="checkbox"/> Yes _____
	Inability to perform activities of daily living without help (ex. bathing, dressing, walking) <input type="checkbox"/> No <input type="checkbox"/> Yes _____

Are there any special problems that you would like to discuss with the doctor today? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please describe:

What language do you use primarily? <input type="checkbox"/> English <input type="checkbox"/> Other: _____	Information reviewed and discussed with patient by:
Do you learn best by: <input type="checkbox"/> Reading <input type="checkbox"/> Listening <input type="checkbox"/> Seeing a demonstration <input type="checkbox"/> Other _____	

Pigmented Lesion Group – Medical History & Registration – New Patient

Name: _____ Date of Birth: _____ MRN# _____ PLG# _____

A history of melanoma in a blood relative is an important part of your medical history. A confirmed history can indicate a need for preventive screening exams and counseling about lifestyle factors such as sun exposure for both you and your immediate family. Because of the importance of family history, we try to determine your relationship to other Pigmented Lesion Group patients as well as to any other relatives you may have with melanoma. Please be aware that information about your family history could be shared with other family members who may become patients here also.

Has anyone else in your family been a patient of the Pigmented Lesion Group? No Yes, please list below:

Full name of relative	Birth date (or age)	Relationship to you	Any address information that you can provide
_____	_____	_____	_____
_____	_____	_____	_____

Have any other blood relatives (not listed above), had melanoma skin cancer? No Yes, please list below:

Full name of relative	Birth date (or age)	Relationship to you	Date of first melanoma?	Is the relative alive?	Date and cause of death, if deceased.
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

How many people in your immediate family* have had cancer (other than skin cancer)? (put zero if none): _____
*(*Immediate family includes parents, full brothers and sisters, half brothers and sisters, and biological children. Do not include family members who are not related to you by blood, such as a spouse, stepchild, or adopted child.)*

How many full brothers and sisters do you have, either living or deceased? (put zero if none): _____

How many half brothers and sisters do you have, either living or deceased? (put zero if none): _____

How many biological children do you have, either living or deceased? (put zero if none): _____

Women’s hormone levels may influence how moles and melanoma behave. Your doctor always should know if you might be pregnant, and we would also like some additional pregnancy information. This is so we can learn more about the biological effects of gender and reproductive hormones.

For females only – pregnancy history.

Have you ever been pregnant?	Are you currently pregnant?	Are you still having menstrual periods?
<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> Yes (but currently/recently pregnant)
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> No, stopped/stopping due to natural menopause
		<input type="checkbox"/> No, stopped due to causes other than natural menopause
		<input type="checkbox"/> No, have never had menstrual periods

How many times have you been pregnant? _____
(Count all pregnancies which resulted in a live birth or went full term)

What month and year did your last pregnancy end? _____
(Use today’s date if pregnant now)

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Your eye color, hair color, skin color, and skin’s tendency to burn are also important parts of your medical history that can indicate a need for preventive screening exams and counseling about lifestyle factors such as sun exposure. Please choose the one answer for each of the following questions which best describes you.

Which of the following best describes your natural eye color?

- Blue
- Green
- Grey
- Hazel
- Light brown
- Dark brown
- Black

Which of the following best describes your natural hair color when you were a teenager? (put current hair color for children)

- Blond
- Red
- Light brown
- Brown
- Black

Which of the following best describes you?

- White
- Black
- Asian/Pacific Islander
- American Indian/Alaskan native
- Other, please state: _____

As a teenager, how would your skin burn if you had no tan and were exposed to strong sunlight* for one-half hour without protective sunscreen?

(*Strong sunlight is noonday sunlight on the brightest, clearest day in summer.)

- Would get painful sunburn with blisters
- Would get painful sunburn, but not any blisters
- Would get a non-painful sunburn
- Would not get any sunburn
- Not a teenager yet

As a teenager, how would your skin appear after repeated and prolonged exposure to sunlight?

- Not tan at all
- Lightly tanned
- Moderately tanned
- Very brown and deeply tanned
- Not a teenager yet

What is your current occupation? _____

Please read and complete the signature and date lines on the following research and teaching consent.


Hospital of the University of Pennsylvania
Pigmented Lesion Group
Research and Teaching Consent Form

As a patient of the University of Pennsylvania Pigmented Lesion Group, I understand that clinical information is gathered into my medical record as part of my care and that during the course of my care biopsies or excisions of skin lesions may be clinically indicated.

I consent to the use of my medical records and residual surgical material (i.e., the part of a pathology specimen that is not used for diagnosis) by the Pigmented Lesion Group for medical education and research. I understand that any information about me that is used for education and/or research purposes will be treated confidentially and I will not be personally identified in the reporting of the results. I also understand that use of these materials for research or teaching will not impact directly on my clinical care.

I understand that my consent is entirely voluntary and that I may refuse the use of my clinical information/materials for medical education/research purposes without affecting the health care I receive at the Hospital of the University of Pennsylvania.

I understand that I may ask any questions I have about the educational and research activities of the Pigmented Lesion Group at this time. If I have any further questions, I may contact Nancy Jones, R.N. or Michael Ming, M.D. at 215-662-6926.

Please sign here  _____
Patient’s signature
(Parent or guardian’s signature if under age 18)

_____ Date

Name: _____ Date of Birth: _____ MRN# _____ PLG# _____

Please complete the signature and birth date lines on the following release which will be used to request copies for your Pigmented Lesion Group chart of any medical records you may have relating to melanoma, pigmented lesions, or related cancers.

Please sign the below form even if you think all of your medical records are already here. The rest of the form can be left blank (we will fill in the rest if necessary).

Medical Records Release

I, _____ hereby request that copies of the following medical records:
Print name

Operative Records Discharge Summaries

Pathology Reports Microscopic Slides Paraffin Blocks

Radiology Reports Laboratory Reports

relating to:

Approximate treatment/admission date(s): _____


Procedure(s): _____

Under the care of Dr(s): _____

Hospital or Laboratory Name: _____

be sent to:

**Hospital of the University of Pennsylvania
Department of Dermatology
The Pigmented Lesion Group
Maloney – 2
3400 Spruce Street
Philadelphia, PA 19104**

Please sign here 

Patient's signature
(Parent or guardian's signature if under age 18)

Date of Birth

Witness

Request Date

Name: _____ Date of Birth: _____ MRN# _____ PLG# _____

Please complete the following information.

Name: _____	Birth Date: _____
Address: _____	Gender: _____
City: _____	Home Phone Number: _____
State, ZIP code: _____	Work Phone Number: _____
Email address: _____	Cell Phone Number: _____
Social Security #: _____	Call during day at home or work number? _____

Please provide contact information for your next of kin and an alternate emergency contact.

Next of kin: _____	Emergency contact: _____ (Relative or friend NOT residing at same address)
Relationship to you: _____	Relationship to you: _____
Address: _____	Address: _____
City, State, ZIP code: _____	City, State, ZIP code: _____
Phone Number: _____	Phone Number: _____

Please provide the names, addresses and phone numbers of the doctors who should receive copies of your exam notes. Your primary care physician or family doctor should always be on the list. Check the type of care you receive from each doctor on the list.

<u>Referring doctor:</u>	<u>Type of Care:</u>
Name: _____	<input type="checkbox"/> Primary Care (family doctor)
Address: _____	<input type="checkbox"/> Dermatologist
Address: _____	<input type="checkbox"/> Surgeon
Phone Number: _____	<input type="checkbox"/> Oncologist
Fax Number: _____	<input type="checkbox"/> Other: _____

Copies should also be sent to:

Name: _____	<input type="checkbox"/> Primary Care (family doctor)
Address: _____	<input type="checkbox"/> Dermatologist
Address: _____	<input type="checkbox"/> Surgeon
Phone Number: _____	<input type="checkbox"/> Oncologist
Fax Number: _____	<input type="checkbox"/> Other: _____

Name: _____	<input type="checkbox"/> Primary Care (family doctor)
Address: _____	<input type="checkbox"/> Dermatologist
Address: _____	<input type="checkbox"/> Surgeon
Phone Number: _____	<input type="checkbox"/> Oncologist
Fax Number: _____	<input type="checkbox"/> Other: _____

Name: _____	<input type="checkbox"/> Primary Care (family doctor)
Address: _____	<input type="checkbox"/> Dermatologist
Address: _____	<input type="checkbox"/> Surgeon
Phone Number: _____	<input type="checkbox"/> Oncologist
Fax Number: _____	<input type="checkbox"/> Other: _____