ALI HENDI, M.D., P.C.
MEDICAL HISTORY

Name _____ Date of Birth (MM/DD/YYYY) _____

CHECK ALL THAT APPLY TO TODAY'S PROBLEM

A change in:	**A history of:**	**Symptoms:**	
☐ Size	☐ UV light treatments	☐ Tingling	☐ Occasional symptoms
☐ Color	☐ X-ray treatments	☐ Pain	☐ Constant symptoms
	☐ Immunosuppression	☐ Itching	
	☐ Arsenic exposure	☐ Bleeding	

Was a biopsy done? ☐ YES ☐ NO **Any treatment performed? ☐ YES ☐ NO**

Approximate Height: _____ **Approximate Weight: _____**

MEDICAL HISTORY

Medications:☐ None

***Please** list dosages of all medications. You may enter them on this form or provide a list.*

_____

_____

_____

_____

Allergies:☐ None

_____

_____

Major Surgeries/Hospitalizations:☐ None

_____

_____

Medical Illnesses:☐ None

_____

_____

YOUR PAST MEDICAL HISTORY

☐ History of Melanoma	☐ History of atypical moles
☐ History of Squamous Cell Carcinoma	☐ Are you an organ transplant ***recipient***?
☐ History of Basal Cell Carcinoma	☐ None

FAMILY HISTORY

Do you have a family history of any of the following skin cancers?

☐ Basal Cell Carcinoma ☐ Squamous Cell Carcinoma ☐ Melanoma ☐ None

SOCIAL HISTORY

What is your smoking status?

☐ Current smoker	☐ Current every day smoker	☐ Current some day smoker
☐ Former smoker	☐ Non-smoker	☐ Smoker, current status unknown
☐ Unknown if ever smoked		

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MEDICAL HISTORY

Name _____ Date of Birth (MM/DD/YYYY) _____

SOCIAL HISTORY CONT'D

Do you drink alcohol (drinks per week)? ☐ No ☐ < 10 ☐ >10
Do you use IV drugs? ☐ No ☐ Yes
Do you exercise? ☐ No ☐ Yes
Do you use sunscreen? ☐ No ☐ Yes

SYSTEM REVIEW - Check all that apply regarding your health:

DERMATOLOGY

☐ Abnormal scarring
☐ Poor healing

HEMATOLOGY/LYMPH

☐ Blood transfusions
☐ Bleeding problems
☐ Blood clots
☐ Enlarged lymph nodes

CONSTITUTIONAL

☐ Fever
☐ Weight loss

ENT

☐ Glaucoma
☐ Hearing aid
☐ Plastic surgery

CARDIOLOGY

☐ Chest pain
☐ Hypertension
☐ Atrial Fibrillation
☐ Heart Attack
☐ Pacemaker/Defibrillator

MUSCULOSKELETAL

☐ Artificial joints

NEUROLOGY

☐ Stroke
☐ Seizures

PSYCHOLOGY

☐ Anxiety
☐ Depression

ENDOCRINOLOGY

☐ Thyroid disorder

INFECTIOUS DISEASES

☐ Hepatitis
☐ HIV/AIDS
☐ Tuberculosis

RESPIRATORY

☐ Asthma
☐ Emphysema

GASTROENTEROLOGY

☐ Colitis

☐ **None of the above apply**

ALI HENDI, M.D., P.C.
HENDI AMBULATORY SURGERY CENTER, P.C.
Mohs & Dermatologic Surgery

5454 Wisconsin Avenue, Suite 725
Chevy Chase, MD 20815
TEL: 301-986-1006
FAX: 301-986-1056

Patient Name:_____**DOB:**_____**SSN:**_____
Address:_____
City: _____ **State:** _____ **Zip code:** _____
Home Phone:_____**OK to leave detailed message** ☐ **Yes** ☐ **No**
Cell Phone: _____ **OK to leave detailed message** ☐ **Yes** ☐ **No**
Work Phone: _____ **OK to leave detailed message** ☐ **Yes** ☐ **No**
Email Address:_____**OK to email detailed message** ☐ **Yes** ☐ **No**
Marital Status: _____ **Occupation:**_____ **Employer:**_____

Emergency Contact:_____
Relationship: _____ **Phone:** _____
I give permission to release medical information to ☐ **emergency contact**
☐ **and/or** _____**(name)** _____**(phone)**
Do you have an Advanced Directive? ___yes ___no. If yes, did you bring a copy? ___yes ___no

Race (check one):
☐ American Indian or Alaska Native
☐ Asian
☐ Native Hawaiian or Other Pacific Islander
☐ Black or African American
☐ White
☐ Hispanic or Latin
☐ Other Race
☐ Prefer not to disclose

Language (check one):
☐ English ☐ Russian ☐ Indian (includes Hindi and Tamil)
☐ Spanish ☐ Other _____

Referring Physician _____
(name, address, phone #) _____
Primary Care Physician _____
(name, address, phone #) _____
Other Physicians _____
(name, address, phone #) _____
Preferred Pharmacy _____
(name, address, phone #) _____

<u>Primary</u> Insurance Company _____
Policy/Group Number _____
Policy Holder _____
(name, DOB, relationship) _____

<u>Secondary</u> Insurance Company IF NONE-PLEASE WRITE "NONE"_____
Policy/Group Number _____
Policy Holder _____
(name, DOB, relationship) _____