Northside Melanoma & Sarcoma Specialists of Georgia

Name: _____ DOB: _____

MEDICAL ASSESSMENT

PART 1 - SOCIAL HISTORY

Smoking history	☐ Never ☐ Quit ☐ Occasional ☐ Daily	___ packs/day	How long? ____	Date Quit _____
Alcohol history	☐ Never ☐ Quit ☐ Social ☐ Daily	___ drinks per day/wk	How long? ____	Date Quit _____
Recreational Drugs	☐ Never ☐ Past ☐ Active			

Residential Status: ☐ Alone ☐ Lives with family ☐ Lives with friends/roommates ☐ Assisted living ☐ Institutionalized

Highest level of education: ☐ Elementary ☐ Middle School ☐ High school diploma/GED ☐ Undergraduate ☐ Post graduate

PART 2 - MEDICAL HISTORY

Date of last colonoscopy? _____ Date of last mammogram? _____ Date of last pap smear? _____

Date of last flu vaccine? _____ Date of last pneumonia vaccine? _____ Date of last bone density screening? _____

√		Year	√		Year	√		Year
☐	Pulmonary (i.e. Asthma or emphysema)		☐	Anemia		☐	Heart Attack	
☐	Diabetes		☐	Cirrhosis or liver problems		☐	Stroke	
☐	High blood pressure		☐	Seizures or epilepsy		☐	Hepatitis	
☐	Heart condition		☐	Depression or anxiety		☐	Tuberculosis	
☐	Kidney problems		☐	Autoimmune disorder (i.e. rheumatoid arthritis, lupus)		☐	Rheumatic fever	
☐	Stomach ulcer or reflux		☐	Easy bruising or bleeding Problem		☐	HIV	
☐	Non skin cancer		☐	# of Pregnancies?_____ Age(s) at pregnancy?_____ Melanoma during pregnancy?___		☐	Other:	

PART 3 - SURGICAL HISTORY

Type of Illness/Surgery	Date of Surgery	Complications

PART 4 - MEDICATION LIST

Name of Medication	Dosage	Frequency	Name of Medication	Dosage	Frequency

PART 5 – MEDICATION ALLERGIES

Are you allergic to any medication: ☐ Yes ☐ No If yes, please list medications below:

Name of Medication	Reaction

NEW PATIENT FORMS

Northside Melanoma & Sarcoma Specialists of Georgia

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PART 6 - FAMILY HISTORY		
Relationship	**Alive/Deceased**	**Health Issues (Diagnosis) & Age when health issue or diagnosis occurred**
Biological mother		
Biological father		
Children		
Brother		
Brother		
Brother		
Sister		
Sister		
Sister		
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		

Do you have a family history of melanoma? ☐ Yes ☐ No If yes, whom? (Melanoma Patients Only, others please skip to section 8)

PART 7 - SKIN CARE HISTORY (Skin cancer patients only. Others please skip to section 8)

Have you ever been told by a doctor that you had any of the following:		**Where was it on your body?**	**Dates of Surgery**	**Name of doctor(s) who treated you?**	**Hospital, City, and State where you were treated?**
Melanoma skin cancer	☐ Yes ☐ No				
Basal cell skin cancer	☐ Yes ☐ No				
Squamous cell skin cancer	☐ Yes ☐ No				
Other non-melanoma skin cancer	☐ Yes ☐ No				

Do you check your skin regularly for changes? ☐ Yes ☐ No

Have any of your moles changed or do you have any new moles or skin changes? ☐ Yes ☐ No

Have you used a tanning bed in the past? ☐ Yes ☐ No If yes, how often? _____times/week For how long? _____months

If yes, explain:

Skin type:
- ☐ White (always burns, never tans)
- ☐ Beige (usually burns, tans with difficulty)
- ☐ Light brown (sometimes burns, slow tanning)
- ☐ Medium Brown (rarely burns, fast tanning)
- ☐ Dark brown (rarely burns, fast & easy tanning)
- ☐ Black (almost never burns, fast & dark tanning)

Natural hair color:
- ☐ Blonde
- ☐ Red
- ☐ Auburn
- ☐ Light Brown
- ☐ Medium Brown
- ☐ Dark Brown
- ☐ Black

Sunburn history #1: Age at first sunburn? _____ ☐ Red without blisters ☐ Red with blisters

Sunburn history #2: Age at second sunburn? _____ ☐ Red without blisters ☐ Red with blisters

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PART 8 - REVIEW OF SYSTEMS								
Please check the appropriate boxes if you CURRENTLY have any of the following conditions:								
√		Year	√		Year	√		Year
☐	***GENERAL***		☐	Chronic Cough		☐	Dark/black Stools	
☐	Fatigue		☐	Decreased Exercise Tolerance		☐	***GENITOURINARY***	
☐	Fever		☐	Difficulty Breathing		☐	Painful Urination	
☐	Night sweats		☐	Coughing up Blood		☐	Increased Frequency	
☐	Weight loss > 10 pounds		☐	Wheezing		☐	Blood in Urine	
☐	***SKIN***		☐	***CARDIOVASCULAR***		☐	Urinary Retention	
☐	Nail changes		☐	Chest Pain		☐	***MUSCULOSKELETAL***	
☐	New Lesions		☐	Leg Pains with Walking		☐	Decreased Range of Motion	
☐	Skin Color Changes		☐	Leg Swelling		☐	Joint Pain	
☐	Rash		☐	Night Awakening due to Trouble Breathing		☐	Muscle Wasting	
☐	***EYES***		☐	Palpitations		☐	Ears Ringing	
☐	Blurred Vision		☐	Shortness of Breath		☐	Muscle Aches/Pains	
☐	Double Vision		☐	***GASTROINTESTINAL***		☐	***NEUROLOGICAL***	
☐	Glaucoma		☐	Change in Bowel Habits		☐	Dizziness/Vertigo	
☐	***EARS, NOSE, THROAT***		☐	Constipation		☐	Headaches	
☐	Hearing loss		☐	Diarrhea		☐	Numbness/Tingling	
☐	Nose Bleeds		☐	Nausea		☐	Passing Out	
☐	Difficulty Swallowing		☐	Vomiting		☐	Seizures	
☐	***RESPIRATORY***		☐	Bloody Stools		☐	Tremor	

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Name: DOB:

☐	***PSYCHIATRIC***		☐	Appetite Change		☐	Easy Bruising	
☐	Abdominal Pain		☐	Cold Intolerance		☐	Enlarged Lymph Nodes	
☐	Anxiety		☐	Increased Thirst		☐	Prolonged Bleeding	
☐	Depression		☐	Increased Urination		☐	***ALLERGIC/IMMUNE***	
☐	Hallucinations		☐	Muscle Weakness		☐	Seasonal allergies	
☐	Suicidal Thoughts		☐	Hair Changes		☐	Food allergies	
☐	***ENDOCRINE***		☐	***HEMATOLOGY***		☐	Compromised immune system	

Do you take Aspirin or any other non-steroidal anti-inflammatories (i.e., ibuprofen, Motrin, etc)?

Reason for appointment today?

Northside Melanoma & Sarcoma Specialists of Georgia

Name: DOB:

PART 9 – NAVIGATION ASSESSMENT		
Do you have any difficulty with the following areas that would keep you from getting the care that you need and that you would like navigation assistance with?		
Transportation	☐ Yes ☐ No	
Finding or paying for your housing	☐ Yes ☐ No	
Support from family or friends	☐ Yes ☐ No	
Reading, writing or understanding English	☐ Yes ☐ No	
Finding childcare or paying for childcare	☐ Yes ☐ No	
Providing care for another adult	☐ Yes ☐ No	
Location and/or distance to Northside Hospital	☐ Yes ☐ No	
Insurance or co-pays	☐ Yes ☐ No	
Finances	☐ Yes ☐ No	
Employment	☐ Yes ☐ No	
Communication concerns with your healthcare team	☐ Yes ☐ No	
Fear of your illness or expected treatment	☐ Yes ☐ No	
Other healthcare or mental health issues	☐ Yes ☐ No	
Other disabilities	☐ Yes ☐ No	
Scheduling appointments or care	☐ Yes ☐ No	
Difficulty in speaking with physicians	☐ Yes ☐ No	
Additional information:		

980 Johnson Ferry Road NE
Suite 940
Atlanta, GA 30342
Phone: 404-851-6000
Fax: 404-252-2736

NORTHSIDE HOSPITAL

Northside Melanoma & Sarcoma Specialists

Patient Name _____

Date of Birth _____ /_____ /_____
Month Day Year

I understand that my physician has requested to take photographs, videotapes or films of me/the patient for medical documentation or identification while at Northside Hospital. I understand that this photography is a necessary and integral part of my diagnostic or surgical procedure or other treatment. Any such photograph, videotape or film will be handled with the same confidentiality as medical records and will be released only with my consent or in accordance with other appropriate procedures for release of medical Information.

Subject to limitations listed below. Photographs and related information may be published in professional journals or medical books or used for any similar purpose in the interest of medical education, knowledge or research; provided, however, that in any such publication or use the patient will not be identifiable. No protected health information will be released without my/the patient's consent. If I have any questions about what photographs, videotapes or films my physician may take or how that will be used, I understand that I should discuss this with my physician.

I understand that I may refuse consent to photographs or videotapes for the purposes indicated in this form and that my refusal to consent will not affect my ability to obtain treatment at Northside Hospital or from a Northside affiliated practice.

The foregoing consent is subject to the following limitations:

(Indicate any limitation, if none, write "None")

I HAVE READ OR HAD THIS FORM READ TO ME AND FULLY UNDERSTAND ITS CONTENTS, ALL STATEMENTS THAT I DO NOT APPROVE OF WERE STRICKEN BEFORE I SIGNED THIS FORM, IF I AM SIGNING THIS FORM ON BEHALF OF ANOTHER PERSON, TO THE BEST OF MY KNOWLEDGE, I AM LEGALLY AUTHORIZED TO CONSENT ON THAT PERSON'S BEHALF.

I hereby release Northside Hospital, my physician, their employees and agents, successors and assigns and those acting with their permission and upon their authority, or and from any responsibility or claim that may arise by reason of any exercise of the authority granted above.

_____
Witness

_____
Signature of Patient or Legally Representative

_____ AM/PM
Date Time

_____
Relationship to patient if not the patient

_____
Interpreter (if applicable)
Note to staff: if telephone interpretation provided, record name of company and interpreter ID number.

_____
Reason patient unable to sign

Reorder #49243 PP0690 (NMSG_A)
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CONSENT FOR MEDICAL PHOTOGRAPHY