

**Health History**

**Patient Information**

Full Name: \_\_\_\_\_  
 Ontario Health Card Number and Version Code: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Date of Birth (YYYY/MM/DD): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Email: \_\_\_\_\_  
 Emergency Contact (Name & Phone): \_\_\_\_\_  
 \_\_\_\_\_  
 Family Physician (Name): \_\_\_\_\_ Phone: \_\_\_\_\_

**Personal Medical History**

Do you have many (20+) moles or freckles on your body?  Yes  No  
 Do you have fair skin?  Yes  No  
 Do you have light hair?  Yes  No  
 Do you have light-colored eyes?  Yes  No  
 Height \_\_\_\_\_ (cm/in)

If you require additional space for any of the questions below,  
 please submit additional information on a separate sheet.

**Skin Health**

Do you have any moles or spots that you are concerned about?  Yes  No  
 If yes, where are they approximately located? \_\_\_\_\_  
 \_\_\_\_\_  
 Do you have any moles or spots that you have noticed changing?  Yes  No  
 If yes, where are they approximately located and describe the changes (colour, size, shape, or other)? \_\_\_\_\_  
 \_\_\_\_\_  
 Have you ever been diagnosed with skin cancer?  Yes  No  
 If yes, what type and when? \_\_\_\_\_  
 \_\_\_\_\_  
 Have you had any pre-cancerous or suspicious moles/lesions removed?  Yes  No  
 If yes, please describe: \_\_\_\_\_  
 \_\_\_\_\_  
 Do you have a history of other cancers or major illnesses?  Yes  No  
 If yes, please list: \_\_\_\_\_  
 \_\_\_\_\_

# STRATFORD SKIN CANCER SCREENING

444 Douro St., Second Floor  
Stratford, ON, N5A 0E6  
Tel/Txt: (519) 643-8459  
Email: info@StratfordSCS.ca  
Website: StratfordSCS.ca

Do you currently take any medications (including creams or supplements)?  Yes  No  
If yes, please list: \_\_\_\_\_

Do you have any allergies to medications, latex, or adhesives?  Yes  No  
If yes, please list: \_\_\_\_\_

Do you have any experience with epilepsy, ocular light sensitivity or ocular nerve damage/diseases?  Yes  No  
If yes, please specify: \_\_\_\_\_

## Family History

Has anyone in your family been diagnosed with skin cancer?  Yes  No  
If yes, who and what type? \_\_\_\_\_

## Lifestyle & Risk Factors

Do you use sunscreen regularly?  Always  
 Sometimes  
 Rarely  
 Never

Have you experienced frequent or severe sunburns (especially as a child)?  Yes  No  
Do you currently use tanning beds?  Yes  No  
Have you ever used tanning beds?  Yes  No  
If yes to either of the above, approximately how many times? \_\_\_\_\_

Do you spend long periods outdoors for work or recreation?  Yes  No  
Please specify: \_\_\_\_\_

## Consent & Signature

I certify that the above information is accurate to the best of my knowledge and understand it will be used to assist in my skin cancer screening.

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness (if applicant is under 19 years of age): \_\_\_\_\_