Mindarie Keys Medical Centre

Unit 2 / 6 Rothesay Heights MINDARIE WA 6030

Tel: (08) 9407 7311 / Fax: (08) 9407 7355

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Mindarie Keys Medical Centre MoleScan Patient Quesionnaire

Patient Name:____

Date of Birth:____

Address:____

____

Medicare Number____

Mobile No.____

Dermatological History

Please list any prior skin cancers as well as location on body, date of diagnosis and treatment.

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Have you ever used tanning beds in the past? (please circle)	Yes or No
Do you currently use tanning beds?	Yes or No
Has an immediate family member had skin cancer	Yes or No

Family Member______________________________Diagnosis____________________

Any other Dermatology History we should know:

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____

____

____

Medical History

Please list any medical conditions we should be aware of:

____

Please list any medication you regularly take:

Please list any allergies to medications or dressings:

Signature of patient (or guardian if under 18 years):____________________________

Date:____________________________

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Medical Photography Consent Form

(For completion at the time of MoleScan Examination)

Patient Consent

I, <<Patient Demographics:Full Name>>

consent to medical images being made of me or my child/dependant.

I agree that the images may be :
(please circle below to show consent)

Placed in my medical record for future reference.	Yes	No
That de-identified images may be used by health professionals for education and training.	Yes	No
That de-identified images may be used in paper or electronic health publications.	Yes	No

By signing below I confirm that I understand this consent form and that any questions regarding it have been answered by my Doctor.

Signature of Patient/Parent or Guardian
______________________________ Date ______________________
Signature of Doctor

______________________________ Date ______________________