Name:____________________________________Date:____________________

Today's visit is for:________________________________________________

If we have time, I'd also like to discuss:______________________________

*DO YOU REQUIRE PREMEDICATION BEFORE SURGICAL/DENTAL PROCEDURES?* YES/NO

| **CURRENT MEDICATIONS (INCLUDE VITAMINS, SUPPLEMENTS, AND OVER THE COUNTER MEDS)** | |
|---|---|
| 1. | 6. |
| 2. | 7. |
| 3. | 8. |
| 4. | 9. |
| 5. | 10. |

## How did you hear about us?

- Referring Doctor ___________________________
- Primary Medical Doctor__________________________
- Another Dermatologist ________________________
- Newspaper (Which?) _________________________
- The Hook
- The Sprint Yellow Pages
- Other (Specify) ______________________________

**MEDICAL HISTORY: PLEASE CHECK OR FILL IN ALL PHYSICIAN DIAGNOSED MEDICAL CONDITIONS**

- ❑ ***Skin Cancer:***
  - Melanoma; Date:__________
    Location__________________________
  - Squamous Cell Carcinoma
  - Basal Cell Carcinoma
  - Actinic Keratosis (pre-skin cancer)
  - Other:__________________________________
- ❑ ***Dermatological Disease:***
  - Herpes/Cold sores
  - Psoriasis
  - Eczema
  - Acne / Rosacea
  - Blistering Disorder:______________________
  - Healing problems; slow, keloid, bruising
  - Other:__________________________________
- ❑ ***Immunological Disease:***
  - Immune Deficiency
  - HIV / AIDS
  - Lupus or Scleroderma
- ❑ ***Hematology / Oncology:***
  - Cancer; type:___________________________
  - Bleeding Problems
- ❑ ***Rheumatological Disease:***
  - Osteoarthritis
  - Rheumatoid Arthritis
  - Gout
- ❑ ***Psychological / Emotional Disease:***
  - Depression
  - Obsessive - Compulsive
- ❑ ***Gastrointestinal Disease:***
  - Crohn's Disease, Ulcerative Colitis
  - Esophageal Reflux
  - Peptic ulcer
  - Esophagitis
- ❑ ***Cardiovascular Disease:***
  - High Blood Pressure
  - Heart Problems: ________________________
  - Heart Attack; Date:_____________________
  - Pacemaker / AICD
  - Irregular heartbeat
  - High Cholesterol
- ❑ ***Endocrine Disease:***
  - Diabetes
  - Hyperthyroid / Hypothyroid
- ❑ ***Neurological Disease:***
  - Stroke / Aneurysm
  - Seizure / Epilepsy
  - Alzheimer's
  - Fainting
- ❑ ***Liver Disease:***
  - Hepatitis; type:____________
  - Jaundice
- ❑ ***Lung Disease:***
  - Asthma
  - COPD
  - Tuberculosis
- ❑ ***Kidney Disease:***
  - Poorly functioning kidneys
  - Dialysis; type___________________________
- ❑ ***For Female Patients:***
  - Are you pregnant / Planning Pregnancy
  - Polycystic ovarian disease
- ❑ ***Other / Not Listed:***
  - ______________________________________
  - ______________________________________
  - ______________________________________
  - ______________________________________

**MEDICATION ALLERGIES**

| NAME OF MEDICATION | TYPE OF REACTION |
|---|---|
| | ❑ rash ❑difficulty breathing ❑ stomach pain/vomiting ❑ other: |
| | ❑ rash ❑difficulty breathing ❑ stomach pain/vomiting ❑ other: |
| | ❑ rash ❑difficulty breathing ❑ stomach pain/vomiting ❑ other: |

## SURGERIES

| TYPE OF SURGERY | SURGEON | HOSPITAL | DATE |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## HOSPITALIZATIONS (DO NOT INCLUDE SURGERIES LISTED ABOVE)

| REASON | DOCTOR | HOSPITAL | DATE |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## FAMILY MEDICAL HISTORY (PLEASE ADD ANY OTHERS NOT LISTED)

| *Conditions/Problems* | *Family Members affected and exact nature of problems* |
|---|---|
| ❑ Melanoma | |
| ❑ Non-Melanoma Skin Cancer | |
| ❑ Blistering Disorder | |
| ❑ Auto-Immune Disorder | |
| ❑ Psoriasis | |

## SOCIAL HISTORY / HABITS

❑ Occupation______________________________ ❑ Retired
❑ Smoker: _____ packs/day ❑ Non-smoker ❑ Quit smoking in ______
❑ Smokeless Tobacco:______________________________
❑ Alcohol use: ❑ Yes (drinks/week:_____________) ❑ No
❑ Recreational Drug use: ❑ No ❑ Yes _______________________________
❑ Sunscreen use: ❑ Regularly ❑ Rarely ❑ Never
❑ I have traveled outside the United States in the past three months:___________

## TANNING / SUN EXPOSURE

Do you / Have you had
❑ Always burn, never tan
❑ Usually burn, tan w/ difficulty
❑ Sometimes burn, usually tan
❑ Rarely burn, tan easily
❑ At least 1 blistering sunburn
❑ Utilize a tanning bed

## REVIEW OF SYSTEMS: Please mark the symptoms you've been having recently.

**GENERAL**
❑ weight gain / loss
❑ loss of appetite
❑ fever / chills
❑ weakness
❑ night sweats

**SKIN**
❑ rash
❑ lumps
❑ dry/sensitive skin
❑ hives
❑ suspicious moles
❑ suspicious lesions
❑ jaundice
❑ acne
❑ itching
❑ hair loss

**EAR/NOSE/THROAT**
❑ congestion
❑ nosebleed
❑ change in voice
❑ sore throat
❑ difficulty swallowing

**ALLERGY**
❑ runny nose
❑ scratchy throat
❑ itchy eyes
❑ sinus congestion
❑ sneezing

**CARDIOLOGY**
❑ chest pain
❑ palpitations
❑ leg swelling

**MUSCULOSKELETAL**
❑ joint stiffness
❑ leg cramps
❑ joint pain
❑ joint swelling
❑ back pain
❑ neck pain
❑ muscle aches

**RESPIRATORY**
❑ shortness of breath
❑ chest tightness
❑ cough
❑ wheezing
❑ congestion

**PSYCHOLOGY**
❑ depression
❑ high stress level
❑ suicidal thinking
❑ eating disorder
❑ mental or physical abuse
❑ mood swings
❑ obsessive - compulsive tendencies

**ENDOCRINE**
❑ excessive sweating
❑ excessive thirst
❑ excessive urination
❑ heat intolerance
❑ cold intolerance

**BLOOD/LYMPH**
❑ swollen glands
❑ fatigue
❑ varicose veins
❑ easy bruising

______________________________
*Patient Signature* *Date*

**EYES**
❑ decreased vision
❑ eye irritation
❑ eye drainage
❑ blurry vision

**NEUROLOGY**
❑ headache
❑ tingling/numbness
❑ seizures
❑ dizziness

**GASTROENTEROLOGY**
❑ nausea
❑ vomiting
❑ heartburn
❑ abdominal pain
❑ change in bowel habits

**UROLOGY**
❑ difficulty urinating
❑ blood in urine
❑ leaking urine

______________________________
*Physician Signature* *Date*