FAMILY DERMATOLOGY of ALBEMARLE

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Name:_____Date:_____ *DO YOU REQUIRE PREMEDICATION BEFORE*

Today's visit is for:_____ *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 learn about us?

: Primary Care Physician (PCP)_____
: Another Dermatologist _____
: Family/Friend/Co-Worker_____
: The Embarq Yellow Pages
: Other (Specify) _____

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

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

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