# DERMATOLOGY HISTORY and REVIEW OF SYSTEMS

**Patient Name:** _____ **Birth Date:** _____ **Age:** _____

**Reason for today's visit:** _____

Are you allergic to **ANY** medication? ____ No ____ Yes – name and reaction? _____

Have you ever had **LOCAL** anesthesia? ____ No ____ Yes – any bad reaction? _____

List **ALL** medications you are currently taking: **(include all prescriptions, over-the-counter medications, vitamins and herbals)**

_____ _____ _____ _____

_____ _____ _____ _____

## DO YOU CURRENTLY HAVE or HAVE HAD ANY OF THE FOLLOWING?

| YES | NO | | YES | NO | |
|---|---|---|---|---|---|
| ____ | ____ | Skin Cancer (type?) _____ | ____ | ____ | Heart Disease or Murmurs |
| ____ | ____ | ***Family History*** of Melanoma **(parents, siblings or children only)** | ____ | ____ | Pacemaker or Defibrillator |
| ____ | ____ | Personal History of Other Cancer _____ | ____ | ____ | Hypertension (high blood pressure) |
| ____ | ____ | Blistering Sunburns and/or Tanning Bed Exposure **(circle)** | ____ | ____ | Thyroid Disease |
| ____ | ____ | Keloids or Hypertrophic Scarring | ____ | ____ | Hepatitis or other Liver Disease |
| ____ | ____ | Lupus Erythematosus | ____ | ____ | Tuberculosis |
| ____ | ____ | Eczema | ____ | ____ | Seizures or Epilepsy |
| ____ | ____ | HIV or AIDS | | | |
| ____ | ____ | Chronic Pain | **WOMEN:** | | |
| ____ | ____ | Bleeding Tendency and/or Anemia **(circle)** | ____ | ____ | Are You Pregnant? Due Date: ____ /____ /_____ |
| ____ | ____ | Depression and/or Anxiety **(circle)** | ____ | ____ | Are You Breastfeeding? |
| ____ | ____ | Arthritis and/or **ANY** Artificial Joints **(circle)** | | | |
| ____ | ____ | Inflammatory Bowel Disease (Crohn's or Ulcerative Colitis) | List **ANY** other conditions **NOT** noted above: _____ | | |
| ____ | ____ | Asthma | | | |
| ____ | ____ | Diabetes | _____ | | |

## ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS?

| YES | NO | |
|---|---|---|
| ____ | ____ | Cough |
| ____ | ____ | Shortness of Breath |
| ____ | ____ | Fever or Chills |
| ____ | ____ | Night Sweats |
| ____ | ____ | Weight Loss that is Unexplained or Unexpected |
| ____ | ____ | Nausea, Vomiting or Diarrhea |
| ____ | ____ | Pain (Rate: 1 out of 10) _____ |
| ____ | ____ | Fatigue, Lethargy or Malaise |
| ____ | ____ | Mood Changes |

## SKIN TYPE (PLEASE CIRCLE)

- **I** Always burns, never tans
- **II** Always burns, tans less than average
- **III** Sometimes burns, tans average
- **IV** Rarely burns, tans with ease
- **V** Moderately pigmented, always tans
- **VI** Deeply pigmented, never burns

## SOCIAL HISTORY:

Do you drink alcohol? _____ NO _____ YES, how many drinks? _____

Do you smoke or chew? _____ NO _____ YES, what? _____ How often? _____

Do you use IV or illicit drugs? _____ NO _____ YES, what? _____

What is your occupation? _____ Hobbies? _____

_____ Date: _____ /_____ /_____

Patient or Guardian Signature

I have reviewed and discussed the above information with the patient: _____

Signature of Medical Assistant Date

Provider Initials: _____