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** Current Medications: **(include all prescriptions, birth control, over-the-counter medications, vitamins, and supplements)**

_________________________ _________________________ _________________________ _________________________

_________________________ _________________________ _________________________ _________________________

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

YES	NO		YES	NO	
____	____	***PERSONAL HISTORY*** of Skin Cancer (Type?) _____________	____	____	Pacemaker or Defibrillator
____	____	***PERSONAL HISTORY*** of Other Cancer _________________	____	____	Hypertension (High Blood Pressure)
____	____	Blistering Sunburns and/or Tanning Bed Exposure **(circle)**	____	____	Thyroid Condition
____	____	Keloids or Hypertrophic Scarring	____	____	Hepatitis or Other Liver Disease
____	____	Lupus Erythematosus	____	____	Tuberculosis
____	____	Eczema	____	____	Seizures or Epilepsy
____	____	HIV or AIDS	____	____	***FAMILY HISTORY*** of Melanoma **(parents, siblings or children ONLY)**
____	____	Chronic Pain (Location) _____________________________			**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)** _____________			List **ANY** other conditions **NOT** noted above: _____________
____	____	Inflammatory Bowel Disease (Crohn's or Ulcerative Colitis)			____
____	____	Asthma			
____	____	Diabetes			
____	____	Heart Disease or Heart Murmur			

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS?

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

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 per week?______________________________

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 **Parent/Guardian Signature (if under 19 years of age)**

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

Signature of Medical Assistant Date

Provider Initials: _______