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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

<ul style="list-style-type: none"> <input type="checkbox"/> Skin Cancer: <ul style="list-style-type: none"> <input type="radio"/> Melanoma; Date: _____ Location _____ <input type="radio"/> Squamous Cell Carcinoma <input type="radio"/> Basal Cell Carcinoma <input type="radio"/> Actinic Keratosis (pre-skin cancer) <input type="radio"/> Other: _____ <input type="checkbox"/> Dermatological Disease: <ul style="list-style-type: none"> <input type="radio"/> Herpes/Cold sores <input type="radio"/> Psoriasis <input type="radio"/> Eczema <input type="radio"/> Acne / Rosacea <input type="radio"/> Blistering Disorder: _____ <input type="radio"/> Healing problems; slow, keloid, bruising <input type="radio"/> Other: _____ <input type="checkbox"/> Immunological Disease: <ul style="list-style-type: none"> <input type="radio"/> Immune Deficiency <input type="radio"/> HIV / AIDS <input type="radio"/> Lupus or Scleroderma <input type="checkbox"/> Hematology / Oncology: <ul style="list-style-type: none"> <input type="radio"/> Cancer; type: _____ <input type="radio"/> Bleeding Problems <input type="checkbox"/> Rheumatological Disease: <ul style="list-style-type: none"> <input type="radio"/> Osteoarthritis <input type="radio"/> Rheumatoid Arthritis <input type="radio"/> Gout <input type="checkbox"/> Psychological / Emotional Disease: <ul style="list-style-type: none"> <input type="radio"/> Depression <input type="radio"/> Obsessive - Compulsive <input type="checkbox"/> Gastrointestinal Disease: <ul style="list-style-type: none"> <input type="radio"/> Crohn's Disease, Ulcerative Colitis <input type="radio"/> Esophageal Reflux <input type="radio"/> Peptic ulcer <input type="radio"/> Esophagitis 	<ul style="list-style-type: none"> <input type="checkbox"/> Cardiovascular Disease: <ul style="list-style-type: none"> <input type="radio"/> High Blood Pressure <input type="radio"/> Heart Problems: _____ <input type="radio"/> Heart Attack; Date: _____ <input type="radio"/> Pacemaker / AICD <input type="radio"/> Irregular heartbeat <input type="radio"/> High Cholesterol <input type="checkbox"/> Endocrine Disease: <ul style="list-style-type: none"> <input type="radio"/> Diabetes <input type="radio"/> Hyperthyroid / Hypothyroid <input type="checkbox"/> Neurological Disease: <ul style="list-style-type: none"> <input type="radio"/> Stroke / Aneurysm <input type="radio"/> Seizure / Epilepsy <input type="radio"/> Alzheimer's <input type="radio"/> Fainting <input type="checkbox"/> Liver Disease: <ul style="list-style-type: none"> <input type="radio"/> Hepatitis; type: _____ <input type="radio"/> Jaundice <input type="checkbox"/> Lung Disease: <ul style="list-style-type: none"> <input type="radio"/> Asthma <input type="radio"/> COPD <input type="radio"/> Tuberculosis <input type="checkbox"/> Kidney Disease: <ul style="list-style-type: none"> <input type="radio"/> Poorly functioning kidneys <input type="radio"/> Dialysis; type _____ <input type="checkbox"/> For Female Patients: <ul style="list-style-type: none"> <input type="radio"/> Are you pregnant / Planning Pregnancy <input type="radio"/> Polycystic ovarian disease <input type="checkbox"/> Other / Not Listed: <ul style="list-style-type: none"> <input type="radio"/> _____ <input type="radio"/> _____ <input type="radio"/> _____ <input type="radio"/> _____
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MEDICATION ALLERGIES

NAME OF MEDICATION	TYPE OF REACTION
	<input type="checkbox"/> rash <input type="checkbox"/> difficulty breathing <input type="checkbox"/> stomach pain/vomiting <input type="checkbox"/> other: _____
	<input type="checkbox"/> rash <input type="checkbox"/> difficulty breathing <input type="checkbox"/> stomach pain/vomiting <input type="checkbox"/> other: _____
	<input type="checkbox"/> rash <input type="checkbox"/> difficulty breathing <input type="checkbox"/> stomach pain/vomiting <input type="checkbox"/> 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
<input type="checkbox"/> Melanoma	
<input type="checkbox"/> Non-Melanoma Skin Cancer	
<input type="checkbox"/> Blistering Disorder	
<input type="checkbox"/> Auto-Immune Disorder	
<input type="checkbox"/> Psoriasis	

SOCIAL HISTORY / HABITS	TANNING / SUN EXPOSURE
<input type="checkbox"/> Occupation _____ <input type="checkbox"/> Retired <input type="checkbox"/> Smoker: ____ packs/day <input type="checkbox"/> Non-smoker <input type="checkbox"/> Quit smoking in ____ <input type="checkbox"/> Smokeless Tobacco: _____ <input type="checkbox"/> Alcohol use: <input type="checkbox"/> Yes (drinks/week: _____) <input type="checkbox"/> No <input type="checkbox"/> Recreational Drug use: <input type="checkbox"/> No <input type="checkbox"/> Yes _____ <input type="checkbox"/> Sunscreen use: <input type="checkbox"/> Regularly <input type="checkbox"/> Rarely <input type="checkbox"/> Never <input type="checkbox"/> I have traveled outside the United States in the past three months: _____	Do you / Have you had <input type="checkbox"/> Always burn, never tan <input type="checkbox"/> Usually burn, tan w/ difficulty <input type="checkbox"/> Sometimes burn, usually tan <input type="checkbox"/> Rarely burn, tan easily <input type="checkbox"/> At least 1 blistering sunburn <input type="checkbox"/> Utilize a tanning bed

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

<p>GENERAL</p> <input type="checkbox"/> weight gain / loss <input type="checkbox"/> loss of appetite <input type="checkbox"/> fever / chills <input type="checkbox"/> weakness <input type="checkbox"/> night sweats <p>SKIN</p> <input type="checkbox"/> rash <input type="checkbox"/> lumps <input type="checkbox"/> dry/sensitive skin <input type="checkbox"/> hives <input type="checkbox"/> suspicious moles <input type="checkbox"/> suspicious lesions <input type="checkbox"/> jaundice <input type="checkbox"/> acne <input type="checkbox"/> itching <input type="checkbox"/> hair loss <p>EAR/NOSE/THROAT</p> <input type="checkbox"/> congestion <input type="checkbox"/> nosebleed <input type="checkbox"/> change in voice <input type="checkbox"/> sore throat <input type="checkbox"/> difficulty swallowing	<p>ALLERGY</p> <input type="checkbox"/> runny nose <input type="checkbox"/> scratchy throat <input type="checkbox"/> itchy eyes <input type="checkbox"/> sinus congestion <input type="checkbox"/> sneezing <p>CARDIOLOGY</p> <input type="checkbox"/> chest pain <input type="checkbox"/> palpitations <input type="checkbox"/> leg swelling <p>MUSCULOSKELETAL</p> <input type="checkbox"/> joint stiffness <input type="checkbox"/> leg cramps <input type="checkbox"/> joint pain <input type="checkbox"/> joint swelling <input type="checkbox"/> back pain <input type="checkbox"/> neck pain <input type="checkbox"/> muscle aches <p>RESPIRATORY</p> <input type="checkbox"/> shortness of breath <input type="checkbox"/> chest tightness <input type="checkbox"/> cough <input type="checkbox"/> wheezing <input type="checkbox"/> congestion	<p>PSYCHOLOGY</p> <input type="checkbox"/> depression <input type="checkbox"/> high stress level <input type="checkbox"/> suicidal thinking <input type="checkbox"/> eating disorder <input type="checkbox"/> mental or physical abuse <input type="checkbox"/> mood swings <input type="checkbox"/> obsessive - compulsive tendencies <p>ENDOCRINE</p> <input type="checkbox"/> excessive sweating <input type="checkbox"/> excessive thirst <input type="checkbox"/> excessive urination <input type="checkbox"/> heat intolerance <input type="checkbox"/> cold intolerance <p>BLOOD/LYMPH</p> <input type="checkbox"/> swollen glands <input type="checkbox"/> fatigue <input type="checkbox"/> varicose veins <input type="checkbox"/> easy bruising	<p>EYES</p> <input type="checkbox"/> decreased vision <input type="checkbox"/> eye irritation <input type="checkbox"/> eye drainage <input type="checkbox"/> blurry vision <p>NEUROLOGY</p> <input type="checkbox"/> headache <input type="checkbox"/> tingling/numbness <input type="checkbox"/> seizures <input type="checkbox"/> dizziness <p>GASTROENTEROLOGY</p> <input type="checkbox"/> nausea <input type="checkbox"/> vomiting <input type="checkbox"/> heartburn <input type="checkbox"/> abdominal pain <input type="checkbox"/> change in bowel habits <p>UROLOGY</p> <input type="checkbox"/> difficulty urinating <input type="checkbox"/> blood in urine <input type="checkbox"/> leaking urine
_____ <i>Patient Signature</i> <i>Date</i>		_____ <i>Physician Signature</i> <i>Date</i>	