

DERMATOLOGY HISTORY and REVIEW OF SYSTEMS

V: 01/1/2024

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	ng: (inclu	ide all prescriptions, over-the-o	counter medications, vitamins and herbals)

DO YOU CURRENTLY HAVE OF 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?			SKIN TYPE (PLEASE CIRCLE)			
YES	NO					
	Cough	1	Always burns, never tans			
	Shortness of Breath	11	Always burns, tans less than average			
	Fever or Chills		Sometimes burns, tans average			
	Night Sweats	IV	Rarely burns, tans with ease			
	Weight Loss that is Unexplained or Unexpected	v	Moderately pigmented, always tans			
	Nausea, Vomiting or Diarrhea	VI	Deeply pigmented, never burns			
	Pain (Rate: 1 out of 10)					
	Fatigue, Lethargy or Malaise					
	Mood Changes					

		SOCIAL HISTO	RY:			
Do you drink alcohol?	NO	YES, how many d	rinks?			
Do you smoke or chew?	NO	YES, what?		How often?		
Do you use IV or illicit drugs?	NO	YES, what?				
What is your occupation?		Hobb	pies?			
Date:				/	/	Patient
or Guardian Signature						

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