

Medical Information

Name: _____

Date of visit: _____

Reason for visit: _____

Past Medical History

Basal Cell Carcinoma Yes No

Seasonal Allergies Yes No

Squamous Cell Carcinoma Yes No

Asthma Yes No

Melanoma Yes No

Atopic Dermatitis (Eczema) Yes No

Other: _____

Family History

Basal Cell Carcinoma Yes No

Seasonal Allergies Yes No

Squamous Cell Carcinoma Yes No

Asthma Yes No

Melanoma Yes No

Atopic Dermatitis (Eczema) Yes N

Other: _____

Social History

Occupation: _____ Tobacco Yes No Alcohol Yes No Occasional

Other: _____

Review of Systems

(please describe any current problems in the following body systems; describe positive responses on the right)

Constitutional (fever, unintentional weight loss) Yes No _____

Eyes (discharge, dry eyes) Yes No _____

Ears, Nose, Mouth, Throat (any problems?) Yes No _____

Cardiovascular (chest pain, palpitations) Yes No _____

Respiratory (wheezing, shortness of breath) Yes No _____

Gastrointestinal (diarrhea, nausea, vomiting) Yes No _____

Genitourinary (urination, pelvic cramps, discharge) Yes No _____

Musculoskeletal (joint pain, muscle aches) Yes No _____

Neurological (damaged nerves, speech problems) Yes No _____

Psychiatric (depression, anxiety) Yes No _____

Endocrine (diabetes, thyroid problems) Yes No _____

Hematologic/lymphatic (anemia, leg swelling) Yes No _____

Allergic/Immunologic (any problems) Yes No _____

Medical Information

Current Skin Complaints

- New or changing moles Yes No (where?) _____
- Rash Yes No (where?) _____
- Warts Yes No (where?) _____
- Acne Yes No (where?) _____
- Hair loss Yes No (describe) _____
- Nail disorder Yes No (describe) _____
- Psoriasis Yes No (where?) _____
- Cosmetic concerns Yes No (describe) _____
- Other skin issues Yes No (where?) _____

Medications

(List all current medications including creams, over-the-counter meds, vitamins, herbal supplements, suppositories, eye drops, etc)

(If you are being evaluated for a rash or skin allergy, list all other medications taken at any time during the past month)

Medication Allergies _____

_____ No known drug allergies

Signed _____ Date: _____