

# Advanced Dermatology & Skin Cancer Center

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Review of Systems**

Please check any of the following that you have now or have had recently:

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Fever/Chills   | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Rash               | <input type="checkbox"/> Itching         |
| <input type="checkbox"/> Weight Changes | <input type="checkbox"/> Diarrhea        | <input type="checkbox"/> Skin Color Changes | <input type="checkbox"/> Hair Changes    |
| <input type="checkbox"/> Heartburn      | <input type="checkbox"/> Constipation    | <input type="checkbox"/> Nail Changes       | <input type="checkbox"/> Swelling Ankles |

**Past Medical History**

Drug Allergies (List Reactions): \_\_\_\_\_

Other Allergies (food, seasonal, etc....): \_\_\_\_\_

Current Medications: \_\_\_\_\_

Do you take Aspirin? Yes No      Coumadin (warfarin)? Yes No      Ibuprofen? Yes No      Plavix? Yes No

Have you ever had any of the following? (Please Check)

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Herpes I (fever blisters)    | <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Seizures        | <input type="checkbox"/> Malignant Moles   |
| <input type="checkbox"/> Herpes II                    | <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Anemia          | <input type="checkbox"/> Skin Cancer       |
| <input type="checkbox"/> Hepatitis                    | <input type="checkbox"/> High Cholesterol       | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Scarring          |
| <input type="checkbox"/> HIV                          | <input type="checkbox"/> Heart Attack           | <input type="checkbox"/> Arthritis       | <input type="checkbox"/> Bleeding Tendency |
| <input type="checkbox"/> Tuberculosis                 | <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Lung Disease    | <input type="checkbox"/> Artificial Joints |
| <input type="checkbox"/> Asthma                       | <input type="checkbox"/> Bad Veins              | <input type="checkbox"/> Kidney Disease  | <input type="checkbox"/> Organ Transplant  |
| <input type="checkbox"/> Hayfever                     | <input type="checkbox"/> Mitral Valve Prolapse  | <input type="checkbox"/> Eye Disease     | <input type="checkbox"/> Chemotherapy      |
| <input type="checkbox"/> Eczema                       | <input type="checkbox"/> Pacemaker              | <input type="checkbox"/> Liver Disease   | <input type="checkbox"/> X-Ray Treatments  |
| <input type="checkbox"/> Reaction to local anesthesia | <input type="checkbox"/> Bruise Easily          | <input type="checkbox"/> Other: _____    | <input type="checkbox"/> Other: _____      |

Which is true for you? (check)       Always burn – Never tan       Always burn – Sometimes tan  
 Sometimes burn – Always tan       Never burn – Always Tan

How many blistering sunburns have you had? \_\_\_\_\_      Sunscreen Use (check):     Daily     Sometimes     Never

Females Only:      Are you pregnant? (circle) Yes No      Are you planning to become pregnant? (circle) Yes No

Family History: Medical conditions that have occurred in your family (check):

Disease/Condition	Mother	Father	Sibling	Other Blood Relative	Comments
Allergies					
Arthritis					
Cancer					
Diabetes					
Eczema					
Heart Disease					
High Blood Pressure					
Lung Disease					
Malignant Melanoma					
Psoriasis					
Skin Cancer					
Tuberculosis					

**Social History**

Occupation: \_\_\_\_\_      Hobbies/Leisure Activities: \_\_\_\_\_

Do you smoke?: Yes No    \_\_\_\_\_ packs/day      Do you drink alcohol? Yes No      Do you use recreational drugs? Yes No

**Office Use Only**

Changes to Medical History	Initials	Date	Changes to Medical History	Initials	Date

Reviewed by Provider: \_\_\_\_\_      Date: \_\_\_\_\_