HEALTH HISTORY AND REVIEW OF SYSTEMS

Patient Name: **Date:**

Please check all conditions that apply to you:

Skin Problems:
□Psoriasis
□Eczema
□Keloids
□Warts
□Blistering diseases
□Hives
□Lupus
□discoid
□systemic
□Skin cancer
□Basal cell
□Squamous cell
□Melanoma
□Sunburn history
□Sarcoidosis
□Vitiligo
□Other skin problem(specify)
_____

General Medical Health:
□ Ulcers
□Gastritis/Heartburn
□Gall bladder disease
□Hepatitis/Cirrhosis
□Arthritis
□Anxiety disorder
□Depression
□Other mental illness
□Asthma
□High Cholesterol
□Hay fever/Allergies
□Thyroid disease
□HIV
□Gonorrhea
□Syphilis
□Chlamydia
□Cold sores
□Genital Herpes
□Cancer
Type/Year
_____
_____
_____
□Cataracts
□Glaucoma
□Anemia
□Bruise/bleed easily
□High blood pressure
□Heart disease
□Congestive Heart failure
□Stroke
□Seizures
□Diabetes
□Kidney disorder
□Other_____
_____
_____

Dermatologic Family History—List skin problems of relatives - (reference list above, if necessary)

Mother _____ Father_____
Brother_____ Sister_____
Grandmother_____ Grandfather_____

Females Only

Are you pregnant?	□Yes	□No
Are your periods regular?	□Yes	□No
Are you in/past menopause?	□Yes	□No
Do you use birth control?	□Yes	□No

Type_____

Social History

Do you smoke?	□Yes	□No
Do you ingest caffeine / coffee?	□Yes	□No
Do you do drugs?	□Yes	□No
Do you exercise regularly?	□Yes	□No

Allergies (list all allergies to medicine)

□ I have no known allergies to drugs

□Penicillin □Erythromycin □Cephalosporins □Iodine □IV dye
□Adhesive tape □Sulfur □Other_____

Surgeries

List all minor surgeries in the last five years, and list **all** major surgeries.

_____ _____
_____ _____

Current/Recent Medications (Oral and Topical)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Reason for Visit—please be specific

1._____
_

2._____
_

Reviewed by:_____ Dates_____ _____ _____ _____ _____