ASSOCIATES IN DERMATOLOGY OF TRAVERSE CITY- MEDICAL HISTORY

Name: _____ Occupation: _____

DOB: ___/____/_____ Age: _____ Sex: _____ Referred by:_____

Primary Care Physician: _____

Reason for Visit: _____ Area(s) of Body:_____

How have you treated? _____ When was first Occurrence? _____

PAST MEDICAL HISTORY: (circle all that apply)

Anxiety
Arthritis
Asthma
Atrial Fibrillation
Bone Marrow Transplant
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Other_____
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
High Blood Pressure
HIV/AIDS
High Cholesterol
Hyperthyroidism (high)
Hypothyroidism (low)
Leukemia
Lung Cancer
Lymphoma
Pneumonia Vaccine
Prostate Cancer
Radiation Treatment
Seizures
Stroke
NONE

PAST SURGICAL HISTORY: (please list): NONE

_____

_____

_____

SKIN DISEASE HISTORY: (circle all that apply)

Acne
Actinic Keratosis
Basal Cell Carcinoma
Blistering Sunburns
Other: _____
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Carcinoma
Cancer
NONE

Do you wear sunscreen? YES NO If yes, what SPF? _____ Do you tan indoor/outdoor? YES NO

Do you have a family history of melanoma? YES NO If yes, which relative(s)? _____

MEDICATIONS:

_____

_____

_____

Turn page over

ALLERGIES:

_____

_____

_____

SOCIAL HISTORY:

Do you smoke? Yes__ No__ If yes, how much? _____ **If no**, have you smoked in the past? Yes__ No__

Do you use IV drugs? Yes__ No__ If yes, what type? _____ **If no**, have you used in the past? Yes __ No__

Do you drink alcohol? Yes___ No___ If yes, _____drinks per day/week/month

Do you have a family history of cancer (other than skin)? YES NO It yes, type of cancer(s)? _____

Which relative(s)? _____

REVIEW OF SYSTEMS: Do you **CURRENTLY** have any of following? Circle **Y for YES** or **N for NO**

GENERAL:					
Fever	Y	N	**NEUROLOGICAL:**		
Weight Loss	Y	N	Headaches	Y	N
HEENT:			Seizures	Y	N
Blurred Vision	Y	N	**RESPIRATORY:**		
Sore Throat	Y	N	Chronic Cough	Y	N
ENDOCRINE:			Shortness of Breath	Y	N
Thyroid Problems	Y	N	Wheezing	Y	N
CARDIOVASCULAR:			**HEMATOLOGY:**		
Swelling of Extremities	Y	N	Abnormal Bleeding	Y	N
GASTROINTESTINAL:			**INTEGUMENTARY:**		
Abdominal Pain	Y	N	Bruising	Y	N
Bloody Stool	Y	N	Problems with scarring	Y	N
Bloody Urine	Y	N	Rash	Y	N
MUSCULOSKELETAL:			**PSYCHIATRIC:**		
Joint Pain	Y	N	Anxiety	Y	N
Muscle Pain or Weakness	Y	N	Depression	Y	N

ALERTS: (circle all that apply)

Allergy to Adhesive
Allergy to Topical Antibiotics
Artificial Joint Replacement
Defibrillator
Pacemaker
Latex Allergy
Rapid heart with epinephrine
Require antibiotics prior to a dental/surgical procedure
Allergy to Lidocaine
Artificial Heart Valve
Blood Thinners
MRSA
Pregnant or trying to get pregnant
Breastfeeding

Reason: _____

Preferred Pharmacy Name/Location: _____

PATIENT SIGNATURE: _____ Staff Initials: _____