MEDICAL CENTER DERMATOLOGY - PATIENT HISTORY & REVIEW OF SYSTEMS

____Date_____________________
Please PRINT Patient's Name

I. **What medications are you allergic to, if any? What kind of reaction did you have?**

____

____

II. **Please list all current medications, including topicals, vitamins, and supplements.**

____

____

III. **Have you ever had pre-cancers (actinic keratoses)?** ____Yes ____No ____Don't know
Have you ever had abnormal (dysplastic) moles? ____Yes ____No ____Don't know
Have you ever had skin cancer? ____Yes ____No ____Don't know
If you have had skin cancer, list it below, with date and location on the body.

Melanoma	Yes	No	____________________________
Basal Cell Carcinoma	Yes	No	____________________________
Squamous Cell Carcinoma	Yes	No	____________________________
Unknown type of Skin Cancer	Yes	No	____________________________

IV. **Is there a family history of skin cancer:**

	Yes	No	Which family member
Melanoma	____	____	____________________
Basal or Squamous Cell Carcinoma	____	____	____________________
Unknown type of Skin Cancer	____	____	____________________

V. **How do you describe your skin? (Circle the answer)**
1. Always burns, never tans
2. Usually burns, sometimes tans
3. Sometimes burns, gradually tans
4. Rarely burns, tans easily
5. Very rarely burns, always tans
6. Never burns, always tans

VI. **Estimated number of: (Circle the answer)**

Past sunburns:	None	1	2-10	11-30	More than 30
Tanning bed sessions:	None	1	2-10	11-30	More than 30

VII. **Do you currently use: (Circle the answer)**

Sunscreen	Yes	No	Sun protective clothing	Yes	No
Hats	Yes	No	Tanning Beds	Yes	No

VIII. **Have you had any of the following? (Check all that apply.)**
____Irritation from bandages
____Fainting with blood draws
____Artificial joint or heart valve
____Irritation from antibiotic ointment
____Keloids
____Pacemaker or Defibrillator (circle the answer)

IX. **(For Women) First day of your most recent menstrual period?** ________________________
Y for yes, N for no: ____Pregnant ____Trying to get pregnant ____Breastfeeding

Reviewed By:
Elizabeth Basler, M.D. _________________ ***Date:*** __/__/__ __/__/__ __/__/__ __/__/__ __/__/__

Annette Harris, M.D. __________________ ***Date:*** __/__/__ __/__/__ __/__/__ __/__/__ __/__/__

Allyson Kopel, M.D. __________________ ***Date:*** __/__/__ __/__/__ __/__/__ __/__/__ __/__/__

____Date__________________
Please PRINT Patient's Name

X. Have you ever smoked? Yes No Packs per day? _____ How many years? ______
How much alcohol do you drink? ____
What is your occupation?____

XI. Please list any surgeries, hospitalizations or serious injuries and the year of occurrence:
____

XII. Have you had any of the following? (Check all that apply.)

Now	Past		Now	Past	
____	____	Diabetes	____	____	Bleeding Tendency
____	____	Thyroid Problem	____	____	Blood Disease or Anemia
____	____	Menstrual Irregularity	____	____	Vein Trouble or Phlebitis
____	____	Excessive hair growth	____	____	Blood Clots
____	____	Eczema/Sensitive Skin	____	____	Heart Disease
____	____	Asthma	____	____	High Blood Pressure
____	____	Other Lung Disease	____	____	Epilepsy
____	____	Hay Fever/Sinus	____	____	Stroke or Paralysis
____	____	Food Allergy	____	____	Other Neurologic Disease
____	____	HIV/AIDS	____	____	Arthritis
____	____	Tuberculosis	____	____	Back Trouble
____	___	Hepatitis or Jaundice	____	____	Stomach Ulcer
____	____	Other Liver Disease	____	____	Intestinal or Bowel Disease
____	____	Prostate Trouble	____	____	Cancer (Internal)
					Location_______________
					Date__________________

XIII. Other active health problems:
____
____

XIV. Have you recently had: (Check all that apply)

____	Weight loss	____	Fatigue	____	Headaches
____	Fever	____	Stress	____	Dizziness
____	Nausea	____	Diarrhea	____	Difficulty Swallowing
____	Vomiting	____	Constipation	____	Hearing Problems
____	Sinus Problems	____	Joint Pain	____	Unusual Bleeding or Bruising
____	Hoarseness	____	Muscle Pain	____	Weakness
____	Eye irritation	____	Mouth ulcers	____	Trouble Sleeping
____	Depression	____	Chest Pain	____	Shortness of Breath
____	Rectal Bleeding	____	Sore Throat	____	Menstrual Irregularities
____	Cough	____	Trembling or Shaking		
____	Dental Problems	____	Frequently Feeling Hot or Cold		
____	Frequent Thirst	____	Pain or Bleeding with Urination		
____	Swelling of Legs	____	Frequent Urination (2 or more times during night)		

____ Vision Problems (other than corrective lenses)
____ Numbness, Tingling, Burning, or Shooting Pains in your Arms or Legs

***Reviewed By*:**
Elizabeth Basler, M.D. _________________ ***Date:*** __/__/__ __/__/__ __/__/__ __/__/__ __/__/__

Annette Harris, M.D. __________________ ***Date:*** __/__/__ __/__/__ __/__/__ __/__/__ __/__/__

Allyson Kopel, M.D. __________________ ***Date:*** __/__/__ __/__/__ __/__/__ __/__/__ __/__/__