Dermatology & Advanced Skin Care Medical History

Patient:_____ Date:_____

Do you have or have you ever had problems with:

☐**NO** ☐**YES** Arthritis
☐**NO** ☐**YES** Asthma
☐**NO** ☐**YES** Blood Disorders
☐**NO** ☐**YES** Diabetes
☐**NO** ☐**YES** Gastrointestinal Disease
☐**NO** ☐**YES** Hay Fever
☐**NO** ☐**YES** Heart Disease
☐**NO** ☐**YES** High Blood Pressure
☐**NO** ☐**YES** Hepatitis/Liver Disease
☐**NO** ☐**YES** Kidney Disease
☐**NO** ☐**YES** Lung Disease
☐**NO** ☐**YES** Psychological Problems
☐**NO** ☐**YES** Neurological Disease
☐**NO** ☐**YES** Received Blood Transfusions
☐**NO** ☐**YES** Thyroid Disease

Family History

Check any of the following medical conditions that have occurred in your family**:**

Disease	Parent	Blood Relative	None	**Disease**	Parent	Blood Relative	None
Acne				**Hay Fever**			
Arthritis				**Hives**			
Asthma				**Lupus**			
Cancer				**Melanoma**			
Diabetes				**Psoriasis**			
Eczema				**Skin Cancer**			

Review of Systems - Are you presently being treated for:

General

☐**NO** ☐**YES** Fever
☐**NO** ☐**YES** Weight Loss/Gain
☐**NO** ☐**YES** Night Sweats
☐**NO** ☐**YES** Extreme Fatigue

Endocrine

☐**NO** ☐**YES** Excess thirst
☐**NO** ☐**YES** Insomnia

Lungs/Respiratory

☐**NO** ☐**YES** Shortness of breath

Cardiovascular

☐**NO** ☐**YES** Chest Pains
☐**NO** ☐**YES** Palpitations
☐**NO** ☐**YES** Ankle Swelling

Psychiatric

☐**NO** ☐**YES** Depression
☐**NO** ☐**YES** Suicidal Thoughts
☐**NO** ☐**YES** Anxiety

Musculoskeletal

☐**NO** ☐**YES** Joint pain
☐**NO** ☐**YES** Back pain

ENT

☐**NO** ☐**YES** Nose Bleeds
☐**NO** ☐**YES** Ringing in ears
☐**NO** ☐**YES** Problems swallowing

Neurological

☐**NO** ☐**YES** Headaches
☐**NO** ☐**YES** Numbness
☐**NO** ☐**YES** Seizures

Eyes

☐**NO** ☐**YES** Irritation of the eyes/eyelids
☐**NO** ☐**YES** Blurred Vision

Gastrointestinal

☐**NO** ☐**YES** Diarrhea
☐**NO** ☐**YES** Constipation
☐**NO** ☐**YES** Eating problems

Lymph/Hematology

☐**NO** ☐**YES** Bleeding
☐**NO** ☐**YES** Sweating

Urinary

☐**NO** ☐**YES** Difficulty urinating
☐**NO** ☐**YES** Frequency
☐**NO** ☐**YES** Burning

Allergy/Immunology

☐**NO** ☐**YES** Dust
☐**NO** ☐**YES** Ragweed
☐**NO** ☐**YES** Moulds
☐**NO** ☐**YES**
Other:_____

Food:_____

Pregnancy Issues

☐**NO** ☐**YES** Currently pregnant
DUE DATE:_____
☐**NO** ☐**YES** Currently breast feeding
☐**NO** ☐**YES** Planning pregnancy

Completed by: ☐ Patient
☐ Nurse/Medical Assistant

Signed by Physician