ANSWER ALL QUESTIONS, USE "NO" ETC., WHERE APPROPRIATE

Extended Medical History/Systems Review

1. Who is your family doctor (one who follows your general health), and in what field is his/her practice (general practice, internal medicine, gynecology, etc.)? ______
2. Where is he/she located? ______
3. When did you see him/her last and for what? ______
4. When was your last general physical exam? ______
5. When were blood tests done last and which ones, if you know? ______
6. Circle if you've had any of the following: high blood pressure, diabetes, heart disease, stomach ulcer, stroke, tuberculosis, positive T.B. skin test, cataracts, glaucoma, psychiatric condition. Explain how long and how treated. ______
7. Have you ever had lupus, arthritis, a thyroid problem, CREST, Raynaud's, scleroderma, Sjogren's, fibromyalgia or auto-immune/ connective tissue disease? ______
8. Have you ever been hospitalized for any reason? State hospital, doctor, year and reason. ______
9. Circle if you ever had keloids, hepatitis, bleeding or coagulation problems, AIDS or HIV, or any blood transfusions. (If yes, please give dates). ______
10. Circle if you have had: mitral valve prolapse, heart valve disease or replacement, pacemaker or defibrillator, any artificial joints or prosthesis. ______
11. Do you have any moles that have changed in size, color, shape or sensation? If so, explain and show location on diagram (reverse side). Be sure the doctor examines this even if it is not your primary reason for being seen today. ______
12. Have you ever had any other medical condition not mentioned above? Explain: ______
13. Have you ever had hormonal problems diagnosed? ______
14. (Women) Is your menstrual cycle regular? If not, explain. ______
15. (Women) Are you possibly pregnant or considering becoming pregnant in the near future? ______
16. (Women) Are you nursing (breast-feeding)? ______ If yes, for how much longer ______

Social History

1. Do you use sunscreens? ______
2. Do you drink alcohol? ______
3. Do you drink more than two cups of coffee/tea, two cans of soda, or other caffeinated beverages daily? ______
4. Do you smoke? ______

Family History

1. Does any member of the family or a friend have a similar skin problem? ______
2. Does anyone in your family have hay fever, asthma, or eczema? ______
3. Does anyone have psoriasis? ______
4. Is there a family history of lupus or autoimmune/connective tissue disease? ______
5. Is there a family history of skin cancer or melanoma? ______

I HAVE COMPLETED ALL OF THE ABOVE TO THE BEST OF MY KNOWLEDGE, AND WILL INFORM THE DOCTOR OF ANY NEW MEDICINES BEING TAKEN OR ADDITIONAL HEALTH CONDITIONS THAT MAY DEVELOP IN THE FUTURE.

______

Signature

PLEASE COMPLETE **BOTH** SIDES. TURN SHEET OVER.

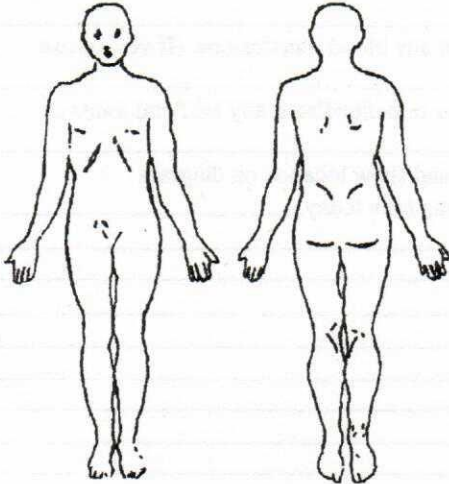
INSURANCE/MEDICARE AUTHORIZATION **Please read and sign.**
I authorize the release, to the insurace carrier or Medicare, of any medical information necessary to process claims and I authorize payment of medical benefits directly to Affiliates In Diseases & Surgery of the Skin, S.C.

______________________________ / ______________________________ / __________
LAST NAME (PLEASE PRINT) FIRST NAME SIGNATURE DATE

MANY SKIN PROBLEMS OR THEIR TREATMENT MAY BE RELATED TO OR AFFECT AN INTERNAL DISEASE THAT MAY SEEM COMPLETELY UNRELATED. THE FOLLOWING MUST ALL BE ANSWERED BEFORE SEEING THE DOCTOR. WRITE ANY EXPLANATIONS NEXT TO THE QUESTION.

Current Condition (HPI/ROS)

1. When did you **first** get the skin problem? ______________________________
2. Where did it **first** start? ______________________________
3. How bad is it? Mild, moderate, severe ______________________________
4. What does it feel like? ______________________________
5. Does anything make it worse/better? ______________________________
6. Is there any itching or pain? ______________________________
7. Please draw **all** the areas where **any** skin rash or growth is by shading in. The doctor **must** see all these areas.



WE ENCOURAGE EXAMINATION OF THE ENTIRE SKIN SURFACE. IF YOU WANT THIS DONE, SIMPLY TELL OUR STAFF AND THEY WILL GET YOU A FULL GOWN.

Medications/Allergies/Systems Review

1. Has your doctor given you or have you obtained anything to put on the skin or to take orally – now or at any time in the past? Please give as closely as possible the names, dosage and total amount taken and for how long.
____
____
____
2. Are you taking **any** other pills, tablets, or other medicines and for what reason? (Please include aspirin, vitamins, birth control pills, laxatives, blood pressure medicine, herbal supplements, etc.)
____
____
3. Are you allergic to any medicines or other substance? If so, write the **name** of the **substance** and **the type of reaction you had to it** (e.g., rash, hives, swelling, nausea/vomiting, cramps, etc.) ______________________________
____
____
4. Have you ever been given **Novocain** by your dentist? ______________________________
Did you ever have an allergic or other reaction to **Novocain** or any local anesthetic? If yes, explain.
____
5. In addition to your skin, have you had burning/itching/watering of eyes, ears, nose, mouth, throat? ______________________________
6. Do you have any swollen glands or lumps? ______________________________

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