

Patient name _____ Date _____ Age _____

Reason for today's visit (chief complaint) _____

Current or past problems with: (review of systems)

	No	Yes	(if yes please explain)
Skin cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear/nose/throat/mouth	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stomach/bowel	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidneys	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis/muscle/joints	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Headaches/seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychological disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid/diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood/bleeding disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies/immune diseases	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
History of X-ray treatment	<input type="checkbox"/>	<input type="checkbox"/>	_____
History of light treatment	<input type="checkbox"/>	<input type="checkbox"/>	_____

Females: Are you pregnant? yes no Planning to get pregnant? yes no Number of children _____
Last menstrual period _____ Periods regular? yes no Hysterectomy yes no

Family History: (past family & social history)

Mother: living deceased Age _____ Father: living deceased Age _____

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

Disease	Mother	Father	Blood Relative	Disease	Mother	Father	Blood Relative
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hayfever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High B/P	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lung disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Melanoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Social history

Do you live alone? yes no Do you smoke? yes no Do you drink? yes no
Do you use recreational drugs? yes no Occupation: _____
Hobbies/leisure activity _____

Medications (oral and topical, including any over the counter products you use on your skin or take by mouth) _____

Allergies to Medications _____

Physician's Signature _____ **Date** _____

