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Dermatology Cosmetic Surgery

Patient name _____ Age _____ Date _____

Allergies:
Current medications:

Reason for today's visit: (chief complaint)

Current or past problems with: (Review of systems)

	Yes	No	(if yes, explain)
General Health	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears/Nose/Throat/Mouth	<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/muscles/joints	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Headaches/seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychological disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid/diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood/bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergic/immunologic	<input type="checkbox"/>	<input type="checkbox"/>	_____

Females: are you pregnant? yes no planning to become pregnant? yes no

Family History: (Past family & social history)

Mother: living/deceased _____ age _____ Father: living/deceased _____ age _____ No of children _____ age(s) _____

Check following medical conditions that have occurred in your family:

<u>Disease</u>	<u>Mother</u>	<u>Father</u>	<u>Blood Relative</u>
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 blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lung disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Malignant 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? no yes

Do you drink alcohol? no yes-frequency _____

Occupation _____

Reviewed _____

Do you smoke? no yes-frequency _____

Do you use recreational drugs? no yes-frequency _____

Hobbies/leisure activities _____

Date _____ Update _____