AIKEN DERMATOLOGY AND SKIN CANCER CLINIC

NAME:_____DATE:_____
Who is your primary doctor:_____
Doctor's address:_____City:_____State:_____Zip:_____
Whom may we thank for referring you?_____

History of Present Illness or Problem

Describe the skin problem that brought you to this office:_____
_____
How long have you had this problem?_____
What have you used to treat the current problem?_____
Have you seen a dermatologist in the past two years? Yes_____No_____Who:_____

Allergies:

Please list all allergies:
Drugs_____
Foods:_____
Latex:_____
Local anesthetics (such as Novocaine)_____
Please describe the reaction that you had to the above allergies:_____
_____

Personal and Family History

Have you ever experienced a blistering sunburn or been treated with chemotherapy or radiation?_____
Have you used Prednisone, Cortisone, or any other steroids over an extended period of time:_____
Please list any other skin problems:_____

Please list any past and present medical problems, hospitalizations, and surgeries (i.e. heart disease, thyroid disease, high blood pressure, cancer):_____
_____
Please list any medications you take_____
_____
Have you or anyone in your family been diagnosed with any of the following: (Please list relationship)?
Basal or squamous cell skin cancer_____Lupus_____
Psoriasis_____Diabetes_____
Melanoma_____Arthritis_____
Other skin disorders_____

Review of Systems

Do **you** have or have **you** ever had the following:

						Frequent headaches	Y	N
Tearing of eyes	Y	N	Pain in joints	Y	N	Ankle swelling	Y	N
Double vision	Y	N	Difficulty walking	Y	N	Angina	Y	N
Glasses	Y	N	Blood in urine	Y	N	History of heart attacks	Y	N
History of cataracts	Y	N	Frequent urination	Y	N	Pacemaker	Y	N
Glaucoma	Y	N	Dark tarry stool	Y	N	Pain on urination	Y	N
Shortness of breath	Y	N	Abdominal pain	Y	N	Unexplained weight loss	Y	N
Persistent cough	Y	N	Swelling of joints	Y	N	Lightheadedness	Y	N
Heart palpitations	Y	N	History of stroke	Y	N	Chest pain	Y	N