



Name: _____ DOB: _____ Date: _____

History of Present Illness

Referred by: _____ Primary Care Physician: _____ Preferred Pharmacy: _____

Reason for visit: _____ How long have you had this issue? _____

On what area of your body? _____

Check the appropriate symptoms:

- Y Itching Y Painful Y Bleeding Y Burning Y Growing Y Comes and goes Y Darkening

List the medications you have used to treat this skin problem: _____

What skin care products do you use? _____

Social History

Tobacco use: Y N Do you use sun protection (clothing, hats, sunscreen)? Y N

Do you drink alcohol? Y N #___ drinks per day

Do you have a history of Y N Use of tanning lights Y N

blistering sunburns? How often do you use a tanning bed or lights? _____

Extensive sun exposure Y N

Exposure to radiation Y N

(other than xrays)

Occupation: _____ Where did you grow up? _____

Past Medical History (check positive answers)

Skin

Skin Cancer: What type, where on your body and when?

Basal Cell
 Carcinoma Squamous Cell
 Melanoma
 Actinic Keratosis
 Atypical Mole
 Eczema
 Psoriasis
 Scar Keloid
 Herpes Simplex
 Acne
 Rosacea

Cardiac

Benign Hypertension
 Hyperlipidemia
 Heart Attack
 Bypass Surgery
 Cardiac Murmur
 Valvular Heart Disease
 Heart Failure
 Cardiac Devices Pacemaker Present
 Cardiac Defibrillator

Musculoskeletal

Osteoarthritis
 Rheumatoid Arthritis
 Osteoporosis
 Presence of Artificial Hip Joint
 Presence of Artificial Knee Joint
 Presence of Artificial Shoulder Joint

Endocrine

Thyroid Disorders
 Diabetes Mellitus
 Ovarian Cyst

Gastrointestinal

Liver Disease
 Irritable Bowel Syndrome
 Crohn's Disease
 Reflux - Heartburn
 Ulcer
 Renal Disease

Immune/Infectious

Hepatitis
 HIV Infection
 Autoimmune Disease
 Tuberculosis
 Leukemia
 Drugs Used (Prednisone, Chemotherapy, Other)

Neurologic

Stroke
 Paralysis
 Epilepsy and Recurrent Seizures
 Multiple Sclerosis
 Migraine Headache

Respiratory

Hay Fever
 Allergies
 Asthma
 COPD

Psychiatric

Depression
 Anxiety
 Bipolar I Disorder
 Other

Hematologic

Bleeding Disorder - Excessive bleeding during surgery
 Miscarriages

Latex Allergy

Allergy to Latex

Ocular

Glaucoma

Cancer

Cancer (other than skin)

No significant medical history
 Other:

Review of Systems (check problems that are present today)

Skin/Nails

Y	N	New or changing moles
Y	N	Localized skin discoloration
Y	N	Acne
Y	N	Skin: a rash
Y	N	Superficial skin pain burning
Y	N	Urticaria/Hives
Y	N	Allergic reaction
Y	N	Telangectasias
Y	N	Skin lesions
Y	N	Skin lesion: bleeds
Y	N	Itching (pruritus)
Y	N	Skin swelling
Y	N	Dry skin
Y	N	Skin/nail infection
Y	N	Symptoms of Nail/Skin thickening

Gynecological

Y	N	Menses abnormal
Y	N	Menarche
Y	N	Planning pregnancy
Y	N	Pregnancy
Y	N	Patient is breastfeeding
Y	N	History of miscarriages #
Y	N	Menopause has occurred

Genitourinary

Y	N	Blood in urine
Y	N	Pain during urination
Y	N	Urinary frequency
Y	N	Penile discharge
Y	N	Vaginal discharge
Y	N	Genital lesion

Musculoskeletal

Y	N	Joint pain, localized
Y	N	Joint swelling, localized
Y	N	Muscle aches
Y	N	Muscle weakness

Hematologic/Lymphatic

Y	N	Clotting problems
Y	N	Easy bleeding
Y	N	Swollen lymph nodes
Y	N	Limb swelling

Psychiatric

Y	N	Depression
Y	N	Anxiety

Cardiac

Y	N	Chest pain
Y	N	Palpitations

Constitutional

Y	N	Feeling fine
Y	N	Recent weight loss (___ lbs)
Y	N	Recent weight gain (___ lbs)
Y	N	Fever
Y	N	Feeling tired

Eyes

Y	N	Loss of part of field of vision
Y	N	White/light spots in field of vision
Y	N	Eyelid skin lesion
Y	N	Eye sores
Y	N	Eye irritation

Gastrointestinal

Y	N	Abdominal pain
Y	N	Diarrhea
Y	N	Nausea
Y	N	Vomiting
Y	N	Constipation

Endocrine

Y	N	Intolerance to heat
Y	N	Intolerance to cold
Y	N	Excessive thirst/fluid intake
Y	N	Deepening of voice
Y	N	Changed sexual interest (libido)
Y	N	Loss of hair from head or body
Y	N	Excessive facial/body hair

Ears, Nose, Throat

Y	N	Skin lesion on ears
Y	N	Skin lesion on nose
Y	N	Skin lesion on lip
Y	N	Lesions in the mouth
Y	N	Lesions on the tongue
Y	N	Stuffiness

Respiratory

Y	N	Shortness of breath
Y	N	Wheezing
Y	N	Cough

Neurologic

Y	N	Tingling
Y	N	Headache
Y	N	Numbness

Immunosuppression

Y	N	Immunosuppression drugs, leukemia, HIV or other
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List any other symptoms not listed above:

Indicate family relationship: Mother, Father, Brother or Sister

Family History: Indicate Mother, Father, Brother or Sister

Y Skin Cancer _____	Y Basal Cell _____	Y Squamous Cell _____	Y Melanoma _____
Y Ovarian Cyst _____	Y Eczema _____	Y Asthma _____	Y Hay Fever _____
Y Psoriasis _____	Y Rosacea _____	Y Acne _____	Y Arthritis _____
Y Inherited Genetic Conditions _____			

List all medications, with dose and frequency:

List all allergies and reactions: