DOCS
DERMATOLOGISTS
OF CENTRAL STATES

REVIEW OF SYSTEMS / MEDICAL HISTORY

(New Patient Visit)

Name: _____ Date of Birth: _____/_____/_____
Last First Middle

History or current problem with any of the following? (Please check all that apply)

Problems with bleeding	☐ Yes □ No	Menstrual Changes	☐ Yes □ No	Allergy to Adhesive	☐ Yes □ No
Problems with healing	☐ Yes □ No	Muscle Weakness	☐ Yes □ No	Allergy to Lidocaine	☐ Yes □ No
Problems with scarring (*hypertrophic or keloid)*	☐ Yes □ No	Neck Stiffness	☐ Yes □ No	Allergy to topical antibiotic ointments	☐ Yes □ No
Abdominal Pain	☐ Yes □ No	Night Sweats	☐ Yes □ No	Artificial Heart Valves	☐ Yes □ No
Anxiety	☐ Yes □ No	Rash/Hives	☐ Yes □ No	Artificial Joints in the last 2 yrs	☐ Yes □ No
Bloody Stool/Urine	☐ Yes □ No	Seizures	☐ Yes □ No	Blood Thinners	☐ Yes □ No
Blurry Vision	☐ Yes □ No	Shortness of Breath	☐ Yes □ No	Defibrillator	☐ Yes □ No
Chest Pain	☐ Yes □ No	Sleeplessness	☐ Yes □ No	MRSA	☐ Yes □ No
Cough	☐ Yes □ No	Sore Throat	☐ Yes □ No	Pacemaker	☐ Yes □ No
Depression	☐ Yes □ No	Thyroid Problems	☐ Yes □ No	Currently pregnant or planning a pregnancy	☐ Yes □ No
Dizziness	☐ Yes □ No	Unintentional Weight loss	☐ Yes □ No	Premedication prior to procedures	☐ Yes □ No
Fever or Chills	☐ Yes □ No	Vaginal Candidiasis	☐ Yes □ No	Rapid heartbeat with epinephrine	☐ Yes □ No
Grey Discoloration of Skin	☐ Yes □ No	Wheezing	☐ Yes □ No	Transplant	☐ Yes □ No
Hay Fever	☐ Yes □ No	Red Eye	☐ Yes □ No	HIV	☐ Yes □ No
Headaches	☐ Yes □ No	Tearing	☐ Yes □ No		
Immunosuppression	☐ Yes □ No	Eye Pain	☐ Yes □ No		
Joint Aches	☐ Yes □ No	Elevated Blood Sugar	☐ Yes □ No		
Joint Replacement	☐ Yes □ No	Uncontrolled Blood Pressure	☐ Yes □ No		

Have you had any of the following conditions? (Please check all that apply)

□ Acne □ Blistering Sunburns □ Dry Skin □ Eczema □ Flaking or Itchy Scalp □ Hay Fever/Allergies □ Psoriasis □ Poison Ivy	☐ Actinic Keratosis (pre-skin cancer) ☐ Precancerous Moles ☐ Squamous Cell Skin Cancer ☐ Basal Cell Skin Cancer ☐ Melanoma Year _____ ☐ Other _____	Have you ever tested positive for TB? Do you have any environmental allergies? If yes, please list _____ Are you allergic to any medications? If yes, please list _____ Have ever tested positive for hepatitis? If yes, please list which type _____	□ Yes □ No ☐ Yes □ No ☐ Yes □ No ☐ Yes □ No

Hypertension:
Have you been diagnosed with high blood pressure/hypertension?
□ Yes □ No
Do you have a family history of melanoma?
□ Yes □ No
If yes, which relative(s)?

Vaccinations:
Have you received your flu vaccination for the current year?
□ Yes □ No

Have you received your pneumonia vaccination?
□ Yes □ No

Are you currently taking any of the blood thinners? (Check from listed below)

□ Aspirin	□ Cilostazol (Pletal)	□ Coumadin (Warfarin)	□ Dipyridamole (Aggrenox)
☐ Effient	□ Eliquis	□Pentoxyfylline (Trental)	□ Plavix (Clipidogrel)
□ Pradaxa	□ Ticagrelor (Brilinta)	☐ Ticlodipin (Ticlid)	☐ Xarelto

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Medications (List All)			
Medication	**Dosage**	**Frequency**	**Route**

Medical Problems (Please list any medical problems for which you are regularly treated)

Surgical History	
Surgery	**Date**

Signature: _____ Date: _____

Printed Name: _____