

Dermatology & Advanced Skin Care, Inc.

Medical History: Review of Systems

Patient: _____

Date: _____

Do you have or have you ever had problems with:

General

- YES NO Fever
- YES NO Weight Loss/Gain
- YES NO Night Sweats
- YES NO Extreme Fatigue

Endocrine

- YES NO Excess thirst
- YES NO Insomnia

Lungs/Respiratory

- YES NO Shortness of breath

Cardiovascular

- YES NO Chest Pains
- YES NO Palpitations
- YES NO Ankle Swelling

Psychiatric

- YES NO Depression
- YES NO Suicidal Thoughts
- YES NO Anxiety

Musculoskeletal

- YES NO Joint pain
- YES NO Back pain

ENT

- YES NO Nose Bleeds
- YES NO Ringing in ears
- YES NO Problems swallowing

Neurological

- YES NO Headaches
- YES NO Numbness
- YES NO Seizures

Eyes

- YES NO Irritation of the eyes/eyelids
- YES NO Blurred Vision

Gastrointestinal

- YES NO Diarrhea
- YES NO Constipation
- YES NO Eating problems

Lymph/Hematology

- YES NO Bleeding
- YES NO Sweating

Urinary

- YES NO Difficulty urinating
- YES NO Frequency
- YES NO Burning

Allergy/Immunology

- YES NO Dust
- YES NO Ragweed
- YES NO Moulds
- YES NO Other: _____

Skin

- YES NO Itchiness
- YES NO Skin Allergies

Pregnancy Issues

- YES NO Currently pregnant DUE DATE: _____
- YES NO Currently breast feeding
- YES NO Planning pregnancy

Completed by: Patient
 Nurse/Medical Assistant

Signed by Physician