

# Atlantic Dermatology

## PERSONAL: Medical and Social History / Review of Systems

PLEASE CIRCLE / ENTER APPROPRIATE INFORMATION

Heart Disease: Heart Attack / Valve Disease / Rhythm Disorder / Pacemaker / Angina / Other Yes/No

Explain:

Hypertension: Yes/No

Hepatitis / Colitis / Crohn's / Stomach Ulcer / Other Yes/No Explain:

HIV Yes/No, Herpes genital / oral - Yes/No Episodes per year:

Blood Thinners / Blood Disorders / Blood Transfusions Yes/No

Kidney / Bladder Problems Yes/No

Asthma / Emphysema / Chronic Bronchitis Yes/No

Smoker Yes/No Pack Years (packs/day x years smoked)

Years discontinued?

Ever tried quitting? Yes/No

Diabetes Yes/No Juvenile / Adult Onset

Thyroid Problems Yes/No

Seizures / Stroke / TIA / Dementia / Parkinsons / Other Neurologic Yes/No

Psychiatric Illness Yes/No

Lupus / Vitiligo / Alopecia Areata Yes/No

Arthritis: Rheumatoid / Psoriatic / Osteoarthritis Yes/No

Atopic Dermatitis / Eczema / Hay Fever / Psoriasis Yes/No

Keloid / Raised Scars Yes/No

Eye Issues / Cataracts Yes/No

Hearing Impairment Yes/No

Immunosuppressed Yes/No

Artificial Joint / Valve Yes/No

Cancer (**other than skin**) Yes/No Type / Date of Diagnosis:

Treatment Type?

Remission?

Other Pertinent Medical / Surgical History (**not family**):

### FAMILY: Pertinent Medical History (other than skin cancer)

Live alone? Yes/No

Widowed / Significant Other / Spouse Name:

Education Level                      Employment Y/N      Retired      Occupation

Hobbies / Activities

STAFF - INITIAL UPDATES:

Name

DOB

Date

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