DERMATOLOGY ASSOCIATES OF SOUTH JERSEY

Medical Information

Name:_________________________________ **Date of visit:**______________________

Reason for visit:____

MEDICATIONS (Please list all current medications including creams, over the counter medications, herbs, vitamins, suppositories, eye drops, etc.)

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MEDICATION ALLERGIES:____

Past Medical History

Basal Cell Carcinoma	Yes	No	Seasonal Allergies	Yes	No
Squamous Cell Carcinoma	Yes	No	Asthma	Yes	No
Melanoma	Yes	No	Atopic Dermatitis (Eczema)	Yes	No

Other:____

Past Surgical History

Family History

Basal Cell Carcinoma	Yes	No	Seasonal Allergies	Yes	No
Squamous Cell Carcinoma	Yes	No	Asthma	Yes	No
Melanoma	Yes	No	Atopic Dermatitis (Eczema)	Yes	No

Other:____

Social History

Occupation:_________________

Tobacco	Yes	No
Alcohol	Yes	No

Review of Systems

(please describe any current problems in the following body systems; describe positive responses on the right)

Constitutional (fever, unintentional weight loss)	No	Yes
Seasonal Allergies	No	Yes
Eyes (discharge, dry eyes)	No	Yes
Ears, Nose, Mouth, Throat (any problems?)	No	Yes
Cardiovascular (chest pain, palpitations)	No	Yes
Respiratory (wheezing, shortness of breath)	No	Yes
Gastrointestinal (diarrhea, nausea, vomiting)	No	Yes
Genitourinary (urination, pelvic cramps,discharge)	No	Yes
Musculoskeletal (joint pain, muscle aches)	No	Yes
Neurological (damaged nerves, speech problems)	No	Yes
Psychiatric (depression, anxiety)	No	Yes
Endocrine (diabetes, thyroid problems)	No	Yes
Hematologic/lymphatic (anemia, leg swelling)	No	Yes
Allergic/Immunologic (any problems)	No	Yes

Sun Exposure

Have you ever had a blistering sunburn?	Yes	No
Have you ever used a tanning bed?	Yes	No
Do you use sunscreen?	Yes	No
Regularly ?	Yes	No

Signed:______________________________ Date:_________________________