SYSTEMS REVIEW-PERSONAL/FAMILY HISTORY

DATE	PATIENT NAME	CHART NO.

ALERTS (PLEASE CIRCLE ALL THAT APPLY)

Hepatitis C Positive
HIV Positive
Allergy to adhesive
Allergy to lidocaine

Artificial heart valve
Artificial joint replacement
Blood thinners
Defibrillator

MRSA
Pacemaker
Require antibiotics prior to surgical procedure

MEDICATION ALLERGIES (PLEASE CIRCLE ALL THAT APPLY)

Aspirin	Penicillin	Codeine	Morphine	None
Sulfa Drugs	Erythromycin	Tetracycline	Keflex (Cephalosporin)	

Other____________________

ALLERGIC/ IMMUNOLOGIC (CIRCLE)
Food, Insect, Jewelry
Ointments, Creams, Lotions, Cosmetics
Hay Fever, Asthma, Sinus, Eyes
Other____

____

DO YOU CURRENTLY HAVE OR HAVE YOU HAD ANY FORM OF CANCER? (CIRCLE)
Skin Cancer
Melanoma
Other____

____

HAVE YOU BEEN HOSPITALIZED DURING THE PAST 3 YEARS? YES NO
For What Condition?_____

CARDIOVASCULAR (CIRCLE)
Blood Pressure
Heart Attack
Irregular Heartbeat
Enlarged Heart (Heart Failure)
Chest Pain
Easy Bleeding
Are You Presently Taking Blood Thinners?
If Yes, What Type?
( ) Coumadin ( ) Aspirin ( ) Plavix
( ) Ticlid ( )Persantine [Dipyridamole]
( ) Other______________________

RESPIRATORY (CIRCLE)
Asthma
Emphysema

GASTROINTESTINAL (CIRCLE)
Ulcer Disease
Colitis or Inflammatory Bowel Disease

Signature____

Date____

GENITOURINARY
Kidney Failure

FEMALE ISSUES (CIRCLE)
Miscarriage
Pregnancy
Are You Currently Using Birth Control Pills?

MUSCULOSKELETAL
Arthritis

NEUROLOGICAL (CIRCLE)
Seizure
Stroke or Paralysis
Tendency to Faint

MENTAL STATUS (CIRCLE)
Tendency Toward Nerves
Tendency Toward Depression

ENDOCRINE (CIRCLE)
Thyroid Disease
Diabetes

HEMATOLOGICAL (CIRCLE)
Anemia
Bleeding or Clotting Disorder

SOCIAL HISTORY
Do You Smoke Presently? Yes No How much?________
Do You Consume Alcoholic Beverages? Yes No How Much?____________

FAMILY HISTORY (CIRCLE)
Do Any Immediate (blood) Relatives Have Any Of The Following? Do Not Consider Yourself.

Hay Fever	Psoriasis
Drug Allergy	Eczema
Diabetes	Skin Problems
Heart Disease	Skin Cancer
Bleeding Disorders	Skin Melanoma

Southern Skies DERMATOLOGY AND SURGERY

SYSTEMS REVIEW-PERSONAL/FAMILY HISTORY

List all medicines, even if you only take them occasionally: Please include laxatives, tranquilizers, sleeping pills, antihistamines, vitamins, aspirin, pain pills, blood thinners, birth control pills, blood pressure pills, fluid pills, etc.

DATE	MEDICATION	DISCONTINUED

PREFERRED PHARMACY:_______________________________________ PHONE #:____

At the time of each visit, the medical information was reviewed and corrected where appropriate.

DATE	PAT. INIT.	STAFF INIT.	M.D. INIT.	DATE	PAT. INIT.	STAFF INIT.	M.D. INIT.